



Texas Employees Group Benefits Program

Cost Management and Fraud Report FY2014



EMPLOYEES RETIREMENT SYSTEM OF TEXAS

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ERS SUPPORTS THE STATE WORKFORCE
BY OFFERING COMPETITIVE BENEFITS
AT A REASONABLE COST.

EXECUTIVE SUMMARY

Texas Employees Group Benefits Program FY14 Cost Management Report

The Employees Retirement System of Texas (ERS) sets and enforces high performance standards for the Texas Employees Group Benefits Program (GBP) to slow the benefit cost trend and ensure that strong measures are in place to prevent fraud and abuse. ERS has managed health insurance benefits for the state since 1976.

The GBP is a cost-efficient plan that provides more than half a million public employees, retirees and their families with competitive, comprehensive health insurance benefits. HealthSelectSM of Texas (HealthSelect) is the basic health plan offered to GBP participants since 1992 and the focus of this report.

ERS is known for implementing best-practice solutions and taking a proactive approach to managing costs. The HealthSelect program reduced plan charges by \$5.8 billion in FY14 due to tighter management of HealthSelect benefit cost trends, low administrative fees and the prescription drug program for Medicare-primary participants.

The GBP spends about
\$7.5 million a day in
health care costs.

That's \$313,000 an hour...
\$5,200 a minute...
\$87 a second.

Employee health insurance is a significant expense for the State of Texas, so it's important to get the most out of every dollar. Professional management and legislative support kept the GBP on a path of fiscal sustainability in FY14, allowing ERS to continue to build the contingency fund and avoid benefit changes.

97¢

HealthSelect spends more than 97 cents of every dollar on health care claims.

FY14 HIGHLIGHTS

Lowered total HealthSelect charges by \$5.8 billion through effective cost management programs.

The HealthSelect third-party administrator contract is on track to meet projected administrative savings of \$25 million through FY16.

Increased the provider network 17% over two years to ensure that participants in all areas of the state have access and choice when using HealthSelect benefits.

Took swift action in the face of a 250% increase in the cost of compound drugs in the first 10 months of FY14, immediately lowering HealthSelect's pharmacy costs by \$6 million a month.

Expanded the award-winning Patient-Centered Medical Home program to include five practices in Texas serving more than 52,000 HealthSelect participants.

Maximized the value of medical and prescription drug benefits for Medicare-primary retirees, collecting \$63 million in subsidies and lowering the cost of the HealthSelect Medicare Rx plan.

Collected \$15.3 million in additional tobacco premium contributions from more than 44,000 participants.

The pharmacy benefit manager (PBM) contract extension continued to meet savings expectations of \$41 million for FY13 and FY14 combined.

HealthSelect has low administrative costs.

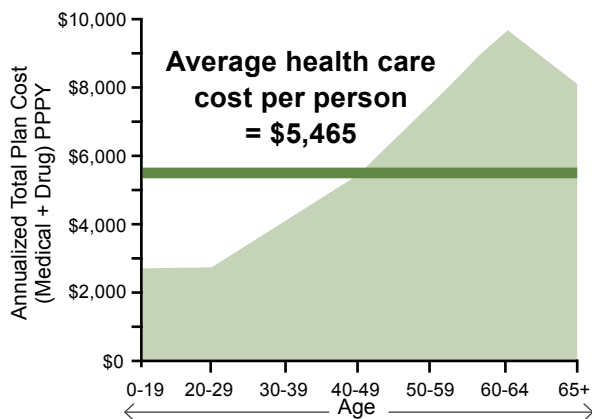
According to federal standards, the GBP is an extremely cost-efficient plan. The Affordable Care Act (ACA) requires large employer plans to spend at least 85 cents of every dollar they collect on health care claims. Administrative costs for large, private health plans nationwide are estimated to be about 12 cents per dollar.¹ The HealthSelect program spends more than 97 cents of every dollar on health care claims.

The self-funded plan benefits from a large risk pool.

HealthSelect is a self-funded insurance plan, meaning that member and state contributions fund all the health care claims. Therefore, the state and the participants – not an insurance company – assume responsibility and bear the risk for paying for all the health care services used.

Figure 1: ERS averages costs so the plan stays affordable for the group.

(HealthSelect average annualized claims cost by age group, all medical and pharmacy claims, FY14)



More than 400,000 employees, retirees and their dependents are grouped together in the HealthSelect “risk pool,” sharing in savings when costs go down and paying more when costs go up. The size of the group brings predictability to budgeting, creates economies of scale and ensures that one catastrophic illness does not dramatically change the average cost of coverage for the year.

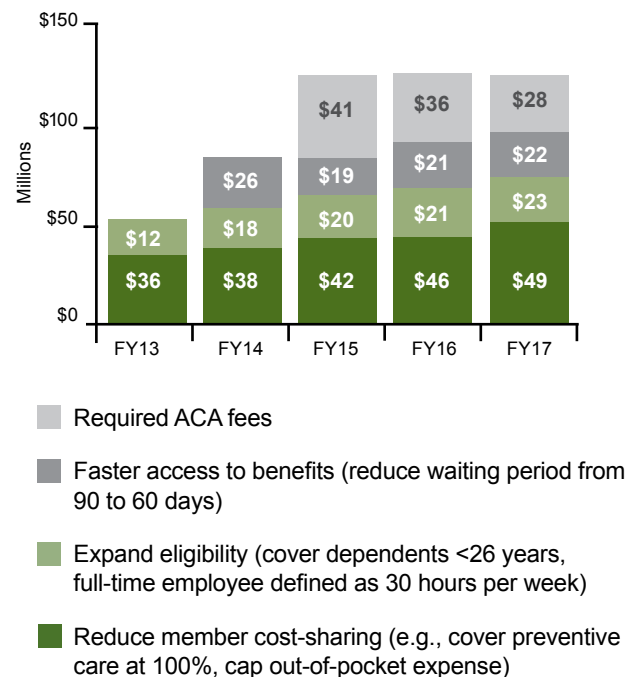
Having a lot of healthy people in the group may lower the average cost, but everyone is different and anyone can have an expensive unforeseen health event. Costs are spread among everyone in the plan so that health insurance never becomes too expensive for people when they need it the most.

Federal health reform’s costs to the plan increased \$36 million in FY14.

The Texas Legislature amended state law in 2011 and 2013 to bring the GBP into compliance with the ACA. ERS has implemented all ACA-required changes to date. See Appendix A for a detailed projection of the ACA’s impact on the GBP through FY17.

In FY14, the plan spent \$85 million on ACA-related costs, nearly half of that toward reducing member cost sharing. In FY15, required ACA fees will increase by 40%, but at the end of calendar year 2016, one of the costliest fees for HealthSelect – the transitional reinsurance fee – will be phased out. For the FY16-17 biennium, ACA-related costs are expected to stabilize to around \$124 million a year.

FIGURE 2: ACA-related fees for the GBP peak in FY15; then costs level off as transitional fees are phased out.



¹ “Paper Cuts: Reducing Health Care Administrative Costs,” Center for American Progress, June 2012

HealthSelect enrollment is holding steady.

Total HealthSelect enrollment declined in FY12 after ERS added Medicare Advantage (MA) options for Medicare-primary retirees. HealthSelect enrollment was virtually identical from FY13 to FY14, and HealthSelect continues to represent 84% of the GBP population. About 11% are enrolled in MA plans and 5% are enrolled in HMOs.

Of the 89,500 Medicare-primary participants in the GBP, about 57,000 Medicare-primary retirees (64%) moved to MA plans. HealthSelect also has two self-funded pharmacy programs, one for Medicare-primary participants, and one for all other HealthSelect participants.

Because many Medicare-primary participants have enrolled in MA plans in the past few years, year-to-year comparisons of HealthSelect medical costs (and savings) in the retiree population can be difficult. This report does not factor in medical cost data for retirees enrolled in the MA plans, only for those in HealthSelect. However, this report does account for prescription drug spending on the entire HealthSelect and MA populations.

FIGURE 3: *More than 57,000 Medicare-eligible participants are enrolled in Medicare Advantage plans.*

Medicare Advantage enrollment has grown 23% since FY12				
	FY11	FY12	FY13	FY14
HealthSelect	496,992	437,473	436,012	436,084
Medicare Advantage	0	46,555	52,335	57,264
HMOs	29,570	25,866	25,367	24,627
TOTAL	526,562	509,894	513,714	517,975

SCOPE OF THE REPORT

ERS manages HealthSelect costs so the state can continue to offer the program within budgeted funds. The ERS Board of Trustees controls insurance costs in two primary ways: the plan design and the professional management of the program.

- The “plan design” is most visible to the people who rely on the plan. It determines what is covered and how much the participants pay in deductibles, co-pays and co-insurance. Starting September 1, 2014, ERS lowered generic drug copays to \$10 for a 30-day supply.
- The “professional management” of the plan includes such things as cost containment and fraud control programs, contracting arrangements with providers, and disease management and wellness programs. Third-party administrators (TPAs) are responsible for the day-to-day management of the plan. An example of professional management is ERS’ decision to tighten reimbursement rules for compound drugs in July 2014, a necessary and successful move to control costs, which is discussed in greater detail on pages 15 and 16 of this report.

ERS contracts with a TPA to manage HealthSelect medical benefits and a pharmacy benefit manager (PBM) to manage prescription drug benefits. UnitedHealthcare is the medical TPA, and Caremark provides PBM services for most of the HealthSelect population. SilverScript, a Caremark subsidiary, provides PBM services for most Medicare-primary participants.

This report focuses on the professional management of HealthSelect – the important ways that ERS and the HealthSelect vendors work behind the scenes to control costs. It also provides a focus on special efforts to address an increasing prescription drug trend, cost-saving initiatives to serve the growing retiree population and the expansion of our Patient-Centered Medical Home project.

“ The half-million Texans in the GBP would fill the University of Texas at Austin football stadium five times over. ”



COST MANAGEMENT OVERVIEW

ERS lowered HealthSelect plan charges \$5.8 billion in FY14

ERS and its vendors proactively manage plan costs to reduce the impact of cost increases on the state and its workforce as much as possible. It's a balancing act to maintain a high level of benefits while also controlling costs. Total FY14 cost-management reductions for HealthSelect were \$5.8 billion. The individual impact of these savings is significant – without cost-management programs, the FY14 member-only contribution would have been \$1,750 a month, rather than \$501.

Negotiating managed care savings.

Two-thirds of all cost management reductions in FY14 – \$4 billion – came from HealthSelect's managed care reimbursement arrangement. Managed care reduces costs for the plan through the negotiation of discounted reimbursement rates with providers who agree to participate in the network. The HealthSelect medical TPA expanded the size of the provider network by 17%, enhancing network access across the state.

Avoiding charges through utilization management.

Nationally, as in HealthSelect, about 20% of the population is responsible for 80% of health care costs. This is even more pronounced in the HealthSelect drug programs, where 20% of participants incur 90% of plan benefits. For this reason, utilization management is an important process that highlights cost drivers, identifies people eligible for clinical management programs and encourages coordination of care.

Utilization management efforts also ensure that primary care doctors are involved in treatment decisions and that prescribed services align with best-practice standards. This process avoided \$90.9 million in charges in FY14.

FIGURE 4: 45% of participants had \$0 in prescription drug claims in FY14.

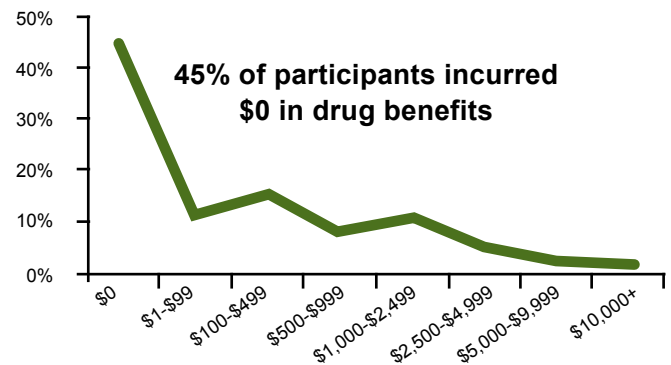
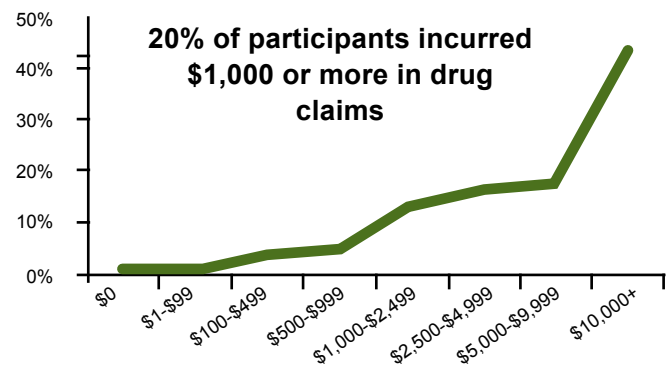
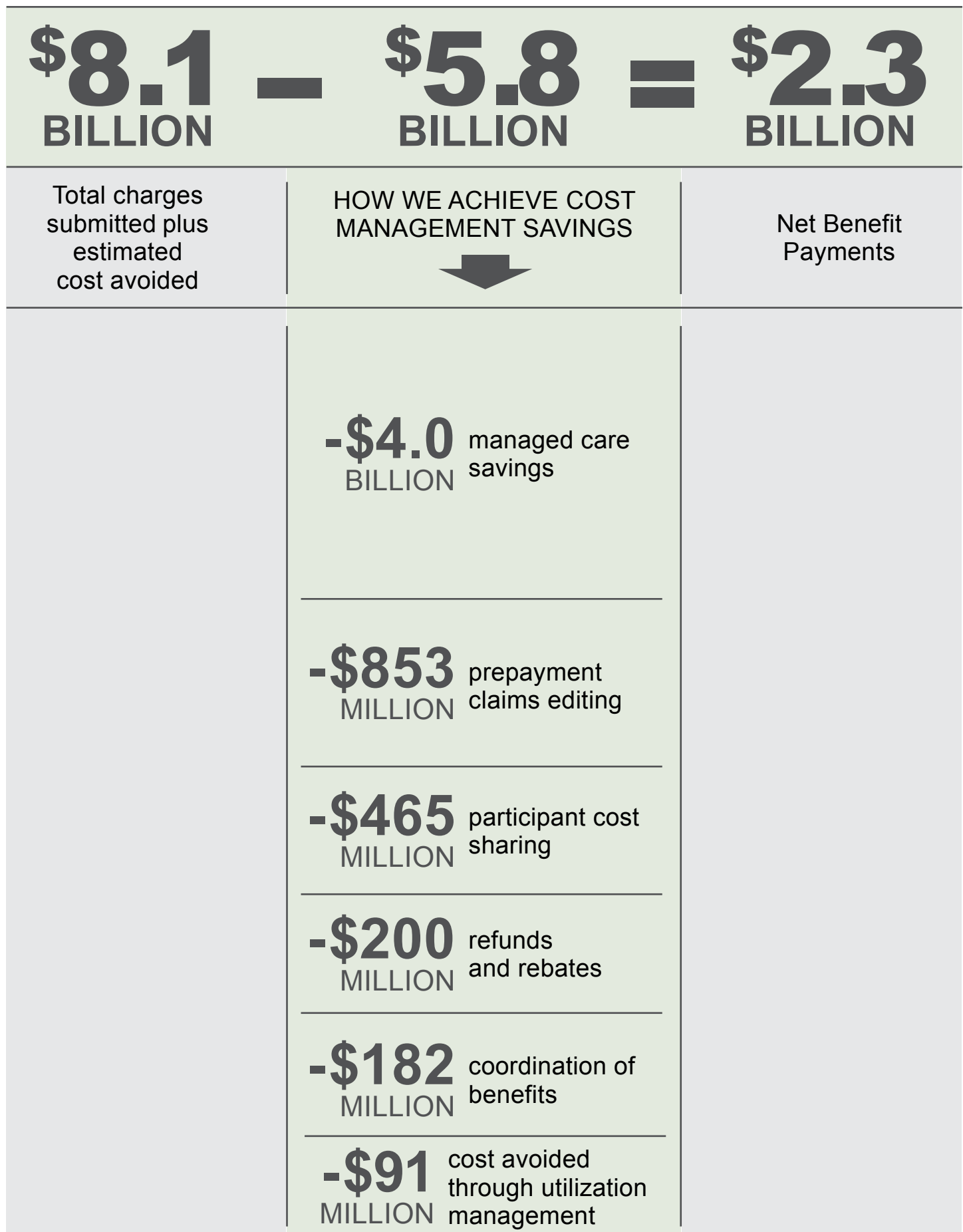


FIGURE 5: 20% of HealthSelect participants received 90% of the prescription drug benefits.



² Kaiser Family Foundation, "Health Care Costs: A Primer. Key Information on Health Care Costs and Their Impact," March 2009, p. 5.

Figure 6: *Texas Employees Group Benefits Program Payments versus Charges, HealthSelect FY14.*



Eliminating ineligible charges through prepayment claims editing.

Prepayment claims editing is the process of screening submitted charges for duplicate claims or late fees, non-covered services or facilities, or services that are not medically necessary. This added checkpoint for accuracy in the claims process eliminated \$853 million in unnecessary charges in FY14.

Coordinating benefits with other insurers and payers.

Coordination of benefits (COB) divides health care expenses among responsible payers, ensuring that HealthSelect doesn't pay claims that may be covered elsewhere. For example, Medicare pays first on claims for Medicare-primary participants, and then ERS coordinates with Medicare to pay the remaining eligible balance. COB saved the plan \$182 million in FY14.

Maximizing refunds, rebates and subsidies.

These strategies leverage outside resources to maximize collections for the plan. From FY06 to FY14, the federal Medicare Part D retiree drug subsidy (RDS) program refunded \$264 million in Medicare retiree drug costs. ERS contracted with an outside vendor to reopen past RDS claims for reconciliation, netting almost \$8 million in additional subsidies in FY14 (included in the total above).

ERS replaced the RDS program for most participants in January 2013 with a new Medicare drug strategy, managed by SilverScript. All retirees are automatically enrolled in this drug program when they become Medicare primary. Through the end of FY14 – just 21 months into the program – ERS received \$86 million in federal subsidies through SilverScript, adding to the \$28 million collected from RDS during that time period, significantly increasing the total annual prescription drug subsidies received on behalf of Medicare-primary retirees.

ERS also received \$54 million in FY14 from the 100% pass-through of all drug manufacturer rebates collected by the PBM. ERS contracts with an independent auditor to conduct an annual audit to confirm that the plan is properly paid 100% of all drug manufacturer rebates.

Conducting audits.

As fiduciaries of the insurance program, ERS has a financial responsibility to the participants to ensure that the plan is operating efficiently and delivering the best value to the state. Since 2011, ERS has undergone five internal and external audits related to the operational, financial, contractual and actuarial processes for the self-funded insurance program. ERS uses the findings of these audits to continuously improve the management of the health insurance benefit program.

The Pharmacy Audit Program protects the financial integrity of the provider network and the plan through a sophisticated set of programs and procedures to deter fraudulent claims, protect against provider abuse, and ensure that network pharmacies comply with HealthSelect guidelines. This program recouped about \$900,000 in FY14.

A successful dependent eligibility audit (DEA) completed in FY12 removed 5% of dependents from the plan and produced \$12.2 million in net savings. In FY14, ERS audited all new dependents added to the plan since FY12, finding another 6,535 ineligible dependents and producing net savings of \$8.7 million. The DEA process has produced significant savings for the program, with a 12-to-1 return on investment. Going forward, ERS will continue to verify all new dependents as they are added to the plan.

Sharing costs with participants.

HealthSelect participants all belong to the group, and every time they make a choice about their health care, it affects the entire group. Increased cost-sharing should encourage people to use less expensive services. It should also influence the total number of health care services used. The goal is to encourage people to get necessary care, while taking an increased role in managing their own health and their costs.

In FY14, employees, retirees and their dependents in HealthSelect paid \$465 million of the total cost of their medical and prescription drug expenses – through coinsurance, deductibles and copays. HealthSelect spent \$28 million in FY14 to ensure that preventive care services were available at no cost to the participants, as required under the ACA.

COST MANAGEMENT FINANCIAL CHART

Components of the Cost Management Financial Chart

Pages 12-23 provide a detailed explanation for each line item in the financial chart starting on the next page.

Screening for Ineligible Charges

Line 2. Utilization Management

Medical and pharmacy utilization management programs helped the plan avoid an estimated \$90.9 million in charges in FY14. Utilization management is a forward-looking process that identifies potentially high-cost claims that could be handled in a more appropriate way, and directs high-risk patients to clinical management programs. This process ensures that prescribed services align with best-practice standards. One example is the redirection of transplant surgeries to Centers of Excellence.

Line 4. Prepayment Claims Editing

HealthSelect further trims costs by screening for ineligible charges through prepayment claims editing. This process lowered plan costs about \$853 million by weeding out duplicate claims and eliminating charges that exceed benefit limits or the plan's allowable amount. Medical claims review ensures that the plan does not pay for services that are not medically necessary.

Prepayment claims editing is an essential part of the GBP's fraud, waste and abuse program, as it is designed to prevent the payment of potentially fraudulent or abusive claims. When claims data fail to meet the requirements of these and other edits, the plan holds claims for individual review by claims processors, the medical review unit and/or the TPA's Fraud, Waste, Abuse and Error team. The independent auditor tests prepayment edits as part of the annual claims audit and verifies that the edits are applied appropriately.

1. Considered charges plus estimated cost avoided	\$ 8,078,961,102
2. Estimated cost avoided due to utilization management	(90,938,134)
3. Considered Charges	7,988,022,968
4. Less charges eliminated through prepayment claims editing	(853,440,041)
5. Eligible Charges	7,134,582,927

Figure 7: Texas Employees Group Benefits Program, HealthSelect FY14 Detailed Payments Versus Charges.*

1. Considered Charges plus Estimated Cost Avoided		\$8,078,961,102
2. Estimated Cost Avoided		
a. Medical	(\$60,632,473)	
b. Pharmacy	(30,305,661)	(90,938,134)
3. Considered Charges		\$7,988,022,968
4. Less Ineligible Charges		<u>853,440,041</u>
5. Eligible Charges		\$7,134,582,927
6. Less Reductions to Eligible Charges		
a. PDP Charge Reductions	\$756,236,499	
b. Provider Discounts and Reductions	3,219,277,320	
c. Medical Copayments and Deductibles	110,398,685	
d. Medical Coinsurance	193,163,702	
e. PDP Cost Sharing	161,019,803	
f. Coordination of Benefits - Medical - Regular	22,814,477	
g. Coordination of Benefits - Medical - Medicare	157,764,154	
h. Coordination of Benefits - PDP	<u>1,169,192</u>	<u>4,621,843,832</u>
7. Gross Benefit Payments		\$2,512,739,095
8. Refunds, Rebates and Guarantees**		
a. PDP Rebates	\$130,156,969	
b. Federal Revenue - Medicare Part D	63,361,490	
c. Subrogation	3,788,243	
d. Pharmacy Audit Refunds	859,359	
e. PBM Audit Refunds	<u>1,805,895</u>	<u>199,971,956</u>
9. Net Benefit Payments		\$2,312,767,139

*Amounts taken from:

- (1) Annual Statistical Review by UnitedHealthcare,
- (2) Annual Experience Accounting prepared by Caremark and SilverScript,
- (3) HealthSelect Prescription Drug Plan data, and
- (4) ERS FY13 CAFR (Federal Revenues - Part D).

**In prior years, the Refunds, Rebates and Guarantee section report has included line item 8f - Hospital Audit Refunds. These amounts are now netted out of the claims data by the third-party administrator, so they are no longer shown as refunds.

Reductions to eligible charges

After eliminating ineligible charges, the plan applies a series of cost management strategies to the \$7.1 billion in remaining eligible charges. Managed care, participant cost-sharing and coordination of benefits saved the GBP \$4.6 billion of the remaining eligible charges in FY14.

Lines 6a-6b. Managed care savings

Nearly \$4 billion in cost reductions came from HealthSelect's managed care reimbursement arrangement. Managed care reduces costs for the plan through the TPA's and PBM's negotiation of discounted reimbursement rates with providers.

6a. Prescription drug program charge reductions	\$ 756,236,499
6b. Provider discounts and reductions	3,219,277,320

The medical TPA leverages its negotiating power in the health care marketplace to give the state, the GBP and the participants access to better rates. The \$4 billion in reduced charges represents the discount taken off the "retail" prices that doctors, hospitals, pharmacies and other facilities would have charged the GBP and its participants had they not been covered by a managed care network.

What is most impressive about the continued growth in HealthSelect managed care savings is that the HealthSelect population has dropped by 57,000 participants since the GBP began to offer Medicare Advantage plans. Since January 1, 2012, about two-thirds of the Medicare-primary population in the GBP enrolled in an MA plan. This change is reflected in HealthSelect's decreased savings from coordination of benefits with Medicare.

Lines 6c-6e. Participant cost-sharing

Sharing costs with participants reduces costs that would otherwise be paid by the plan. In FY14, employees, retirees and dependents that used health care services paid \$465 million through coinsurance, deductibles, and medical and prescription drug copays.

6c. Medical copayments and deductibles	\$ 110,398,685
6d. Medical coinsurance	193,163,702
6e. PDP cost-sharing	161,019,803

Cost-sharing should affect the amount of health care services used by reducing demand. The goal is to encourage people to get needed care, while taking an increased role in managing their own health and their out-of-pocket costs. HealthSelect covers all preventive services at no cost to the member.

FIGURE 8: *Negotiated provider discounts continue to be the greatest source of cost savings to the plan. (HealthSelect FY12-FY14, in millions)*



Member cost-share leveraging.

Because HealthSelect participant copays for prescriptions and doctor visits remain flat, as total charges for these services increase, participants end up paying a smaller

and smaller part of the bill. This phenomenon illustrated in Figure 10 is called “member cost-share leveraging.” This is especially clear in the drug program, where price inflation is a major cost driver.

Figure 9: HealthSelect total member cost-sharing fell after nearly 52,000 Medicare-primary participants enrolled in Medicare Advantage plans. (HealthSelect FY13 and FY14, in millions)

HealthSelect participants had lower overall out-of-pocket costs in FY14

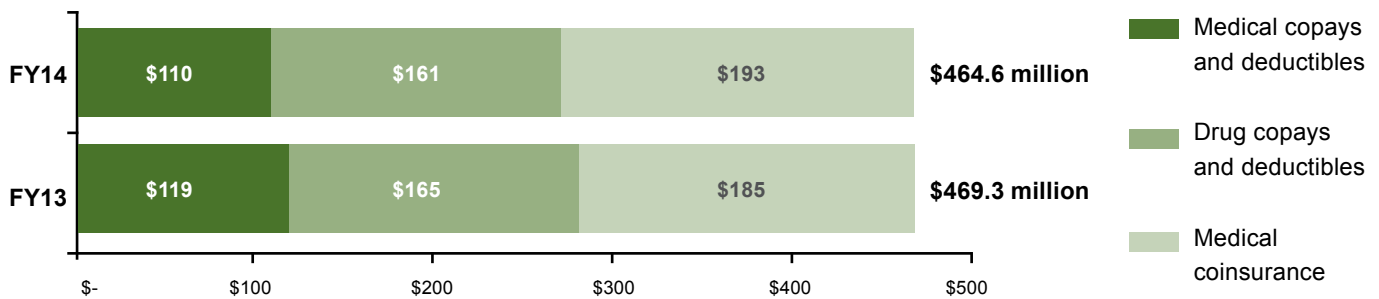
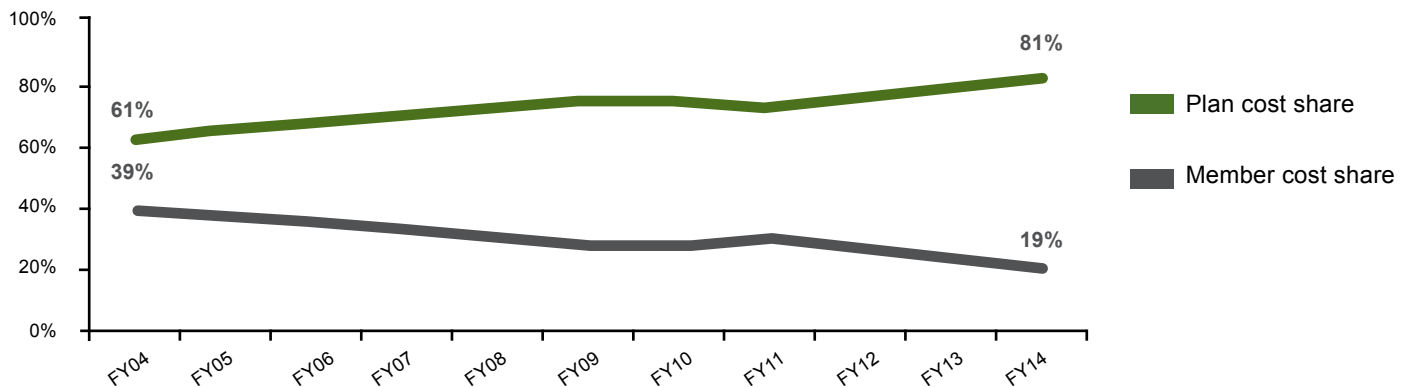


FIGURE 10: HealthSelect participant cost share for prescription drugs is half what it was 10 years ago.

The impact of stable copays in the HealthSelect prescription drug program (member and plan share as percentages of total cost, FY04-FY14)



The Top 10 costliest drug list has historically been dominated by “blockbuster” brand-name drugs, such as Lipitor, Nexium and Cymbalta. With all three of these drugs now available in generic form, specialty and compound drugs have risen to the top of the list.

Compound drugs are specially formulated combinations of two or more medications made in compounding pharmacies. Specialty drugs are expensive medications prescribed for complex chronic and/or life threatening conditions. They often require

special storage, handling and administration, and they involve a significant degree of patient education, monitoring and management.

Compound drugs take the wheel in driving up costs.

In FY14, the projected annual pharmacy trend reached a record high of 22.5% due to an explosion in the cost and use of compound drugs. ERS actions successfully reduced that to 14.1%.

ERS took swift action in response to a 250% increase in the cost of compound drugs in the first 10 months of FY14, immediately lowering HealthSelect's pharmacy costs by almost \$6 million a month. On July 1, 2014, ERS suspended coverage of non-FDA approved bulk chemicals in compound drugs, and began to require

pre-authorization for all compound drugs costing \$300 or more. None of the compound drugs were critical life-saving medications, and since the policy change, ERS has received few complaints from the nearly 12,000 participants who filled a compound drug prescription in FY14.

FIGURE 11: *Top 10 Costliest Drugs for HealthSelect in FY14. (in millions)*

Drug Name	Type	Therapeutic Use	Plan Cost in Millions FY14	Plan Cost in Millions FY13
1. Compound Drugs	Compound	Multiple	\$37.5	\$14.1
2. Humira 	Specialty	Rheumatoid Arthritis	\$21.2	\$17.1
3. Enbrel 	Specialty	Rheumatoid Arthritis	\$19.6	\$16.6
4. Lantus 	Brand	Diabetes	\$18.2	\$12.6
5. Crestor 	Brand	High Cholesterol	\$16.6	\$13.7
6. Novolog 	Brand	Diabetes	\$15.4	\$11.5
7. Sovaldi 	Specialty	Hepatitis C	\$14.8	\$0
8. Nexium ¹ 	Brand	Gastric Reflux	\$12.1	\$10.6
9. Victoza 	Brand	Diabetes	\$10.8	\$8.4
10. Abilify 	Brand	Antidepressant	\$10.6	\$8.8

¹A generic version of Nexium was released in May 2014.

Figure 12 shows the exponential increase in the plan cost attributable to specialty drugs in HealthSelect over the past decade. In FY14, specialty drug spending represented 25% of total drug plan cost, compared to 2.7% in FY01.

The plan paid 45,000 specialty claims last year. Some plans have substantially increased the patient cost share for specialty drugs. Even if ERS could save \$6 million by increasing member specialty copays to \$150, it doesn't move the needle on a \$172 million problem.

Incentives to use generic drugs work.

One cost management feature of the HealthSelect prescription drug program is the use of a "three-tier" copay structure. The participant's cost share is based on the drug's tier, with a 30-day prescription for a generic drug being the least expensive (\$15 in FY14), compared to a preferred brand drug (\$35) and a non-preferred brand drug (\$60).

In a 2014 survey of 136,000 GBP-eligible state and higher education employees, ERS asked participants about cost-saving plan features they had used. By far, generic drugs were the most popular cost-saving feature, with about 67% of all respondents saying that they had asked their doctor for a generic medication in the past year. This is one of the few cost-conscious behaviors that crossed all categories – essentially two-thirds of all respondents had asked for a generic – including men and women, and low-income and high-income workers.

HealthSelect's generic dispensing rate continues to rise; at 80.2%, it is 2.3% higher than it was in FY13. However, the problem with relying upon generics to bend the cost curve is that an effective generic drug may not exist for every condition. New and improved drug therapies are released every day, and as the population ages, the demand grows for more effective treatments for complex chronic health conditions like rheumatoid arthritis.

FIGURE 12: Plan spending on specialty drugs has increased exponentially over the past decade.

HealthSelect specialty drug costs have grown exponentially

HealthSelect annual plan cost for specialty drugs, FY01-FY14 (in millions)

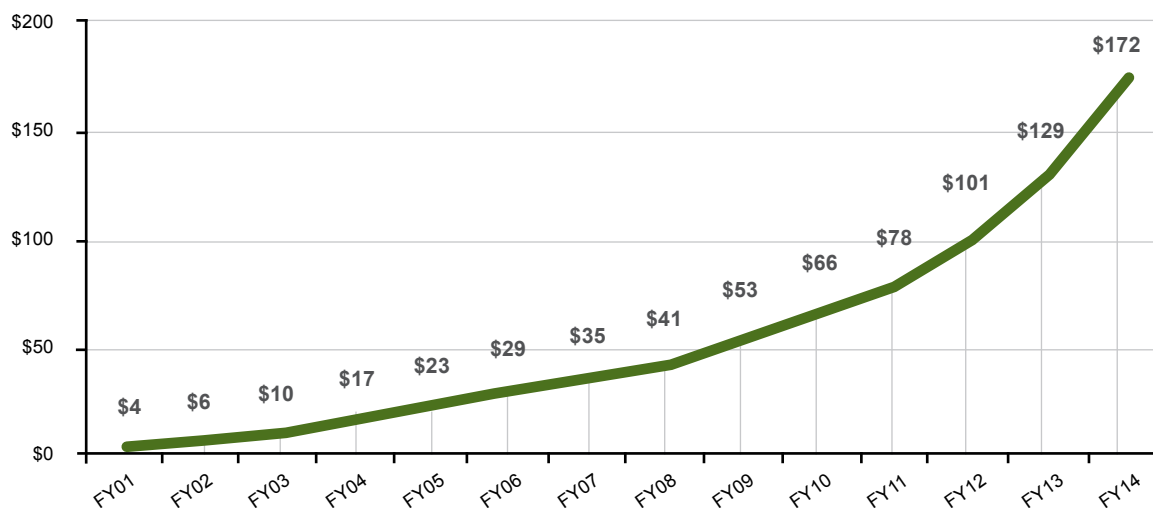
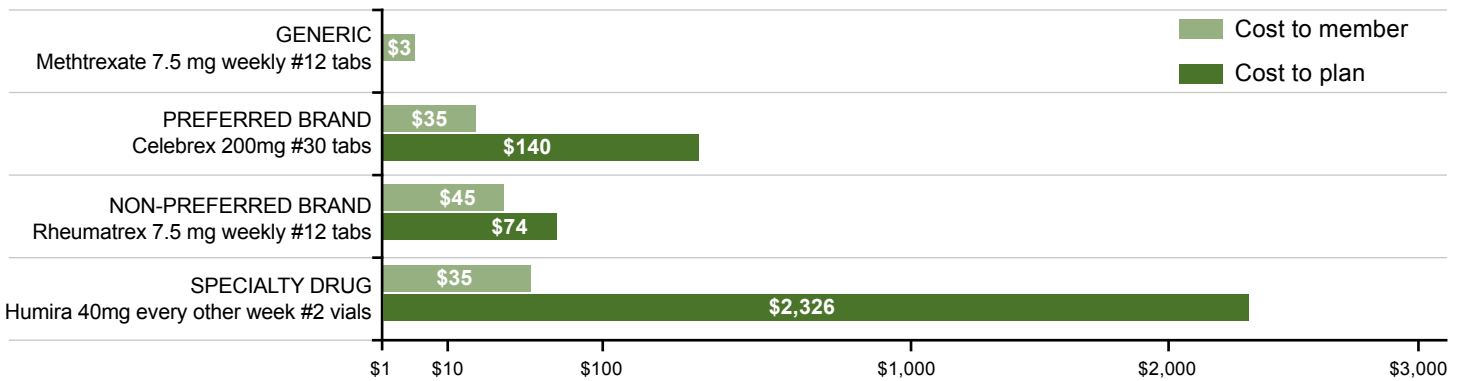


Figure 13: How does choosing a generic medication compare to other options?

Four Rheumatoid arthritis medications, 30-day supply, retail



Starting September 1, 2014, ERS reduced the price of a 30-day supply of generic medication to \$10, down from \$15, in an effort to encourage the use of generic medication. This change brought the GBP more in line with other large plans and has the potential to continue to reduce pharmacy costs. However, the continued savings depend on two things: (a) doctors' prescribing patterns and (b) members' behavior.

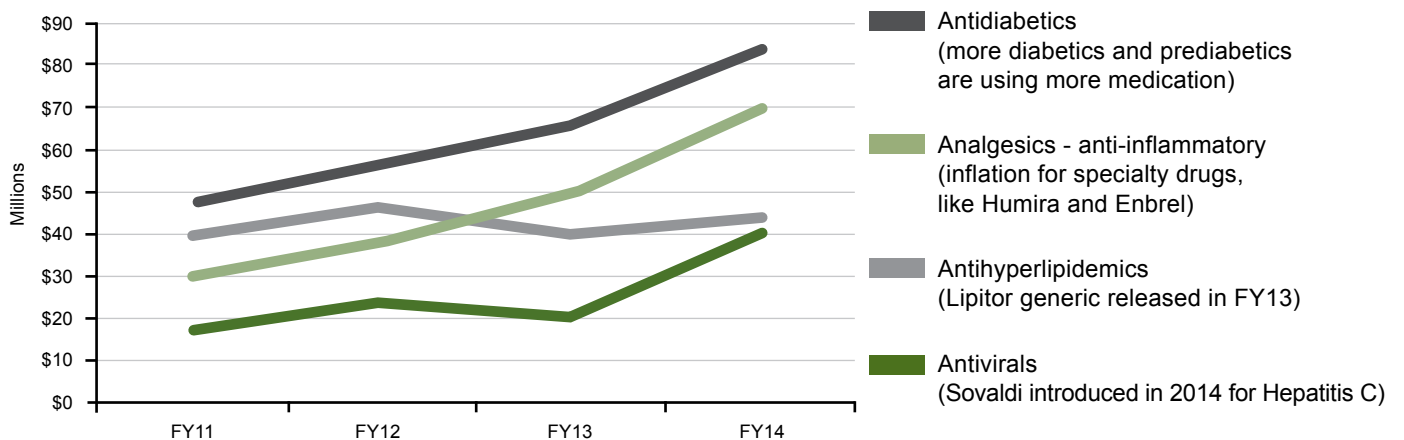
Figure 13 shows the positive impact on plan costs when a doctor prescribes a generic rheumatoid arthritis

drug, rather than a brand or specialty drug. Many doctors do try a course of "step therapy" – testing the effectiveness of a generic drug first before graduating their patients to more powerful, expensive specialty drugs. These medications may deliver better results, but they expose patients to health risks, and the cost impact to the plan is evident. This is why the rising cost of specialty and compound drugs have offset much of the plan's financial gain from the increased use of generics.

Figure 14: After Lipitor went generic, plan spending dropped for the entire therapeutic class.

Impact on plan costs when a blockbuster drug goes generic

(HealthSelect FY11-FY14, in millions)

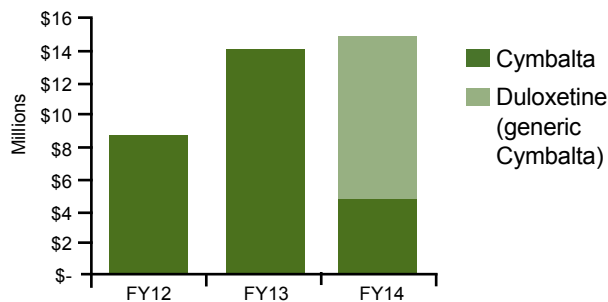


As seen in Figure 14, when the Lipitor patent expired, it had a positive impact on the plan costs for the entire therapeutic class of drugs. In other words, the plan's total

cost for antihyperlipidemics – drugs that lower cholesterol – was positively affected by the release of one generic drug.

Figure 15: Cymbalta lost its patent in FY14, but plan costs have not yet fallen.

Plan savings from generic Cymbalta will not be realized until FY15



The “blockbuster gone generic” headline for FY14 was Cymbalta, an extremely popular antidepressant that is also prescribed “off label” for pain management, seizure control and other reasons.

Figure 15 shows the impact to plan costs when Cymbalta went generic in December 2013, four months into FY14. A dramatic shift toward generic usage occurred, which had an immediate positive effect on member out-of-pocket costs, but the full potential for plan savings on Cymbalta may not be realized until FY15.

It takes time for a “blockbuster generic” to save money for the plan for two reasons:

- (1) The year before the brand name goes off patent, the manufacturer artificially increases the price, in anticipation of losing money on the generic.
- (2) For the first six months after the generic is released, the patent-holder has the exclusive right to produce the generic, and to set the price. After that window expires, competition in the marketplace will drive the cost down.

Lines 6f-6g. Coordination of benefits

Another way to reduce eligible HealthSelect charges is coordinating the payment of claims with other health care payors. For example, when retired participants become eligible for Medicare, GBP health benefits become secondary, which means that the plan only pays eligible health care expenses after Medicare has processed the claim. In FY14, coordination with the Medicare program saved the GBP about \$158 million. Coordination with other insurance programs saved \$24 million.

6f. Coordination of benefits - medical - regular	\$ 22,814,477
6g. Coordination of benefits - medical - Medicare	157,764,154
6h. Coordination of Benefits - prescription drugs	1,169,198

Refunds, Rebates and Subsidies

Line 8a. Prescription drug program rebates

Through arrangements with drug manufacturers, the HealthSelect PBM receives rebates based on the volume of various drugs dispensed under the prescription drug programs it administers. ERS’ PBM contract requires the PBM to return all rebates to the GBP, including a guaranteed minimum. During FY14, ERS received nearly \$130.2 million in rebates. ERS annually conducts an audit to confirm that 100% of all rebates were paid to the plan.

8a. Prescription drug rebates	\$ 130,156,969
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Line 8b. Federal revenue – Medicare Part D.

Starting January 1, 2006, Medicare-primary individuals could enroll in a Medicare Part D prescription drug program, funded in part by the federal government. ERS chose to continue GBP prescription drug coverage for Medicare retirees and offset the cost with federal subsidies received under the Medicare Part D Retiree Drug Subsidy (RDS). Under RDS, the federal government reimbursed ERS for eligible retirees who stayed in the GBP instead of enrolling in Medicare Part D. From FY06 to FY14, ERS collected RDS reimbursements of about \$264 million.

Effective January 1, 2013, ERS moved most Medicare-primary participants to a self-funded Employer Group Waiver Program with a wraparound feature. HealthSelect Medicare Rx, administered by SilverScript, reduced plan costs by \$63.4 million in FY14.

8b. Federal revenue (subsidy) - Medicare Part D	\$ 63,361,490
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Line 8c. Subrogation

The subrogation program allows the plan to recover certain health-related expenses paid on behalf of a participant who has rights of recovery against a third party for negligence or any willful act resulting in injury or illness to the participant. Typically, such recoveries occur in connection with automobile accidents for which a third party is found liable. Subrogation recoveries saved the GBP \$3.8 million in FY14.

8c. Subrogation	\$ 3,788,243
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LANDMARK EVENTS IN THE HISTORY OF THE GBP

1975

SB 18 CREATED THE TEXAS EMPLOYEES UNIFORM GROUP INSURANCE ACT

- ERS was charged with providing health insurance and other optional coverages
-

1976

HEALTH INSURANCE COVERAGE BEGAN FOR STATE EMPLOYEES, RETIREES AND ELIGIBLE DEPENDENTS

- Three fully-insured indemnity plan choices for employees: a high, medium and low plan
- Retirees were enrolled in the equivalent of the high plan

LEGISLATURE APPROPRIATED THE SAME AMOUNT OF MONEY TO EVERY MEMBER TO SPEND ON INSURANCE

- The first year, each member received \$12.50 a month; if any was left over, it could be spent on dependent coverage
-

1978

TWO HEALTH MAINTENANCE ORGANIZATIONS (HMOS) WERE APPROVED FOR PARTICIPATION IN THE GBP FOR FY79

1984

GOVERNOR'S TASK FORCE ON STATE EMPLOYEE HEALTH INSURANCE RECOMMENDED A "SINGLE BENEFIT PLAN"

- The Task Force found the multiple plan arrangement to be "unsustainable" due to adverse selection
-

1985

ERS CONSOLIDATED MULTIPLE PLANS INTO ONE

- ERS consolidated plans, eliminated open enrollment and established evidence of insurability for late entrants
 - ERS implemented the second surgical opinion, preadmission testing for hospital stays, case management, medical necessity claims review and incentives for outpatient surgery
-

1987

FEDERAL LAW AUTHORIZED THE EXTENSION OF COBRA BENEFITS

1989

PRESCRIPTION DRUG CARD WAS ADDED

- Benefits were managed by the health plan administrator, and participants had two levels of copays for their medications

TEXTFLEX FLEXIBLE SPENDING ACCOUNT WAS ESTABLISHED FOR HEALTH CARE EXPENSES

1990

22 HMOS WERE APPROVED FOR PARTICIPATION IN FY91

- Benefits were standardized and financial requirements strengthened to reduce adverse selection and ensure that participants were getting equivalent benefits
- By comparison, in FY14, only two non-Medicare HMOs participate in the GBP

FOR THE FIRST TIME, THE LEGISLATURE PROVIDED AN EXPLICIT CONTRIBUTION FOR DEPENDENT HEALTH COVERAGE

1991

THE LEGISLATURE ADOPTED THE 100% MEMBER-ONLY, 50% DEPENDENT CONTRIBUTION FOR FY92

1992

HIGHER EDUCATION (EXCEPT THE UNIVERSITY OF TEXAS AND TEXAS A&M) JOINED THE GBP ERS IMPLEMENTED HEALTHSELECT OF TEXAS

- A self-funded, managed care, point-of-service health benefit plan with a gatekeeper model
 - Members must coordinate care and specialty referrals through their PCPs
-

1993

ENROLLMENT INCREASED 39.2% DUE TO HIGHER EDUCATION JOINING THE PROGRAM HEALTHSELECT NETWORK HAD 3,000 PRIMARY CARE DOCTORS AND 8,600 NETWORK SPECIALISTS

- The network started in Austin, Dallas, Houston and San Antonio, and it took seven years before statewide coverage was available
 - By comparison, today the HealthSelect network has more than 15,500 PCPs and more than 51,500 specialists
-

1996

HEALTHSELECT BEGAN COVERING ANNUAL VISION EXAM

2000

PRESCRIPTION DRUG BENEFIT WAS ADMINISTERED SEPARATELY

- Medco was the first pharmacy benefit manager (PBM)
-

2001

HEALTHSELECT ADOPTED A THREE-TIERED COPAY STRUCTURE FOR PRESCRIPTION DRUGS A STATE BUDGETARY CRISIS RESULTED IN MID-YEAR PLAN DESIGN CHANGES

- \$600 million in cost-shifting to members
-

2008

IMPLEMENTED TRANSPARENT PBM CONTRACT WITH 100% PASS-THROUGH OF ALL REBATES

- New contract with Caremark saved \$288 million over four years
-

2011

100% DEPENDENT ELIGIBILITY AUDIT

- Removed 5% of dependents and saved \$12.2 million

FUNDING SHORTFALL LED TO FIRST PLAN DESIGN CHANGES IN SIX YEARS

- \$142 million in cost-shifting to members

LAUNCHED PATIENT-CENTERED MEDICAL HOME PILOT PROJECTS

2012

LEGISLATURE IMPOSED AN EXTRA \$30 PER MONTH CONTRIBUTION FOR TOBACCO USERS

IMPLEMENTED MEDICARE ADVANTAGE PPO AND HMO FOR MEDICARE-PRIMARY PARTICIPANTS

2013

HEALTHSELECT IMPLEMENTED A NEW TPA CONTRACT

- Projected to save \$25 million in administrative fees over four years

IMPLEMENTED SILVERSCRIPT, A HEALTHSELECT MEDICARE DRUG BENEFIT FOR MEDICARE-PRIMARY PARTICIPANTS

2014

IMPOSED STRICT PAYMENT RULES TO ADDRESS 250% COST INCREASE FOR COMPOUND DRUGS

PREVENTING AND INVESTIGATING FRAUD

Fraud prevention, detection and investigation are integral components of the overall GBP cost management strategy. ERS takes the necessary steps to ensure that fraud and abuse of the program are prevented or reduced, and that violators are dealt with appropriately.

ERS requires vendors to be diligent in their efforts to prevent, detect, and investigate fraud, abuse and other improprieties. Although fraud and abuse may be confused with each other, fraud implies intent, whereas abuse may occur from provider or participant error.

- Fraud is an intentional deception or misrepresentation by a person who knows that the deception could result in some unauthorized benefit.
- Abuse is a transaction that results in unnecessary cost to the program. One example of this is when participants call an ambulance to take them to regularly scheduled dialysis or cancer treatments when a more cost-effective transportation service could be used. Although this is not considered fraud, it creates a redirection of ambulance resources to non-emergency care, and results in inappropriately expensive charges to the plan. To address this problem, HealthSelect now requires prior authorization before non-emergency

ambulance transportation benefits are available. The Medicare program – which covers many patients with end-stage renal disease and cancer – established a prior-authorization requirement for non-emergency ambulance use on December 1, 2014.

The TPA has a Fraud, Waste, Abuse and Error Division that investigates and refers suspected fraud cases to the proper criminal authorities and to ERS to enforce administrative penalties.

When law enforcement intervention is not necessary, the TPA engages providers in a collaborative process to speed the recovery of overpayments. Examples of anti-fraud and abuse methods include:

- annual auditing of provider claims for incorrect coding, double-billing or falsified data;
- identifying and intervening in cases where abuse of certain drug categories is suspected;
- investigating potentially ineligible dependents through routine eligibility audits; and
- requiring that participants pay for all health care received outside the United States prior to receiving plan reimbursement.

Figure 16: *Fraud is an ongoing concern for all health plans.*

The Fraud, Waste, Abuse and Error (FWAE) team for the HealthSelect program investigates potential fraud and abuse tips from multiple sources including members, providers, government agencies, news etc. The TPA also uses an expansive Advanced Analytics Lab to monitor claims prepayments and post-payments for suspect activity.

In Texas, the FWAE team experts –investigators, clinical review specialists, nurses, doctors, certified coders and analysts – are actively watching claims and saving money through detection and prevention. Prevention safeguards the claims system against potentially abusive providers. Detection identifies suspect providers based on reviews of their claims.

A few examples of the currently open fraud investigations include:

- Some pain management providers may be abusing the system to get paid more through billing errors that include duplicate billing, unbundling, and billing facet joint injections under anesthesia.
- Some Texas providers are misrepresenting services provided to receive higher reimbursement, especially those who perform spinal manipulations under anesthesia.
- One Texas provider is billing the TPA for hernia repairs to get reimbursed for “tummy tucks.” The provider likely knows that tummy tucks are not covered by most health plans; however, hernia repairs are a covered service. Through medical records review, the TPA is able to deny or recover dollars for services that aren’t covered by the health plan.

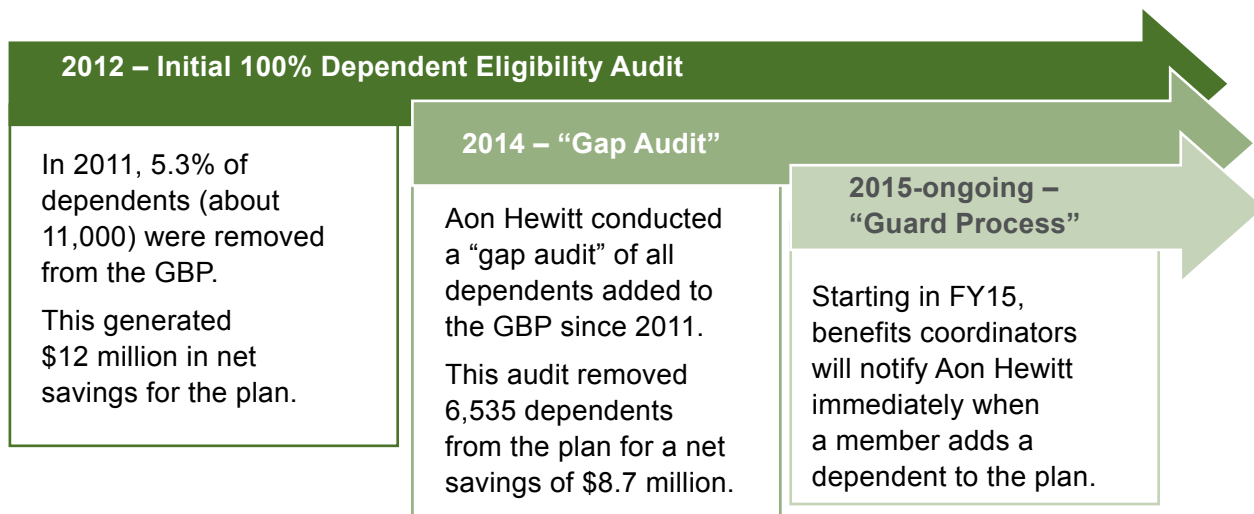
Dependent Eligibility Audit (DEA)

ERS has a fiduciary responsibility to manage health care costs and control fraud. Ineligible dependents increase the cost of health care to the state; therefore, removing ineligible dependents from the GBP reduces state contributions and plan costs.

In FY12, ERS completed a successful dependent eligibility audit that asked all plan members who cover dependents for documentation proving their eligibility for coverage. About 5.3% of dependents (about 11,000) were removed from the plan at a net savings to the plan of \$12.2 million.

ERS conducted a “gap audit” in FY14 of all new dependents added to the plan since FY12, finding another 6,535 ineligible dependents and producing net savings of \$8.7 million. The DEA process has produced significant savings for the program, with a 12-to-1 return on investment. Going forward, ERS will continue to verify all new dependents as they are added to the plan.

FIGURE 17: *Dependent eligibility audits have saved the plan more than \$20 million, for a 12-to-1 return on investment.*



Line 8d-8e. Audit refunds³

The Retail Pharmacy Audit Program includes a sophisticated set of programs and procedures to:

- ensure participating pharmacies’ compliance with program guidelines,
- protect the financial integrity of the provider network and the PDP,
- deter fraudulent claim submissions and
- educate participating pharmacies about the correct procedures and program guidelines.

8d. Pharmacy audit refunds	\$ 859,359
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In addition to auditing the specific retail pharmacies, ERS contracts with an independent auditor to review claims and administrative services to ensure compliance with the PBM contract. This audit reviews all retail pharmacy and mail-order claims.

As part of ERS’ transparent contract with the PBM, the independent auditor examines the rebate contracts between the PBM and pharmaceutical manufacturers to ensure that (a) 100% of all claims are billed to the pharmaceutical manufacturers and (b) ERS receives 100% of all rebate dollars paid to the PBM based on claims experience.

8e. PBM audit refunds	\$ 1,805,895
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³ In prior years, the Cost Management and Fraud Report has included a line item 8(f) Hospital Audit Refunds. These amounts are now netted out of the claims data by the third-party administrator, so they are no longer shown as refunds.

WELLNESS AND DISEASE MANAGEMENT PROGRAMS

The State of Texas provides health insurance so that its workers are healthy, present and productive on the job. Poor health costs both employers and employees time and money. The GBP offers many voluntary wellness programs to help participants improve their quality of life and, it is hoped, to slow the growing cost of health care benefits. ERS supports and promotes wellness in many ways.

WE MAKE SURE EMPLOYEES HAVE WELLNESS BENEFITS THROUGH THE HEALTH INSURANCE PLANS. HealthSelect, HealthSelect MA and the HMOs all have extensive wellness offerings available to employees, retirees and their families.

WE CONDUCT RESEARCH ON PATTERNS OF CHRONIC ILLNESS. We study whether people are taking their medications for chronic illnesses and where they are getting care – for example, do they go to the emergency room when they have an asthma attack, or are they going to their primary care doctor first, before it is an emergency?

WE FOCUS OUR PLAN DESIGN TO ENCOURAGE PEOPLE TO GET THE CARE THEY NEED.

Preventive care is available at no cost to participants. The program also keeps generic drug costs and primary care copays low to make sure everyone can afford to go to the doctor and take the medications they need. Participants also have 24-hour hotline access to registered nurses.

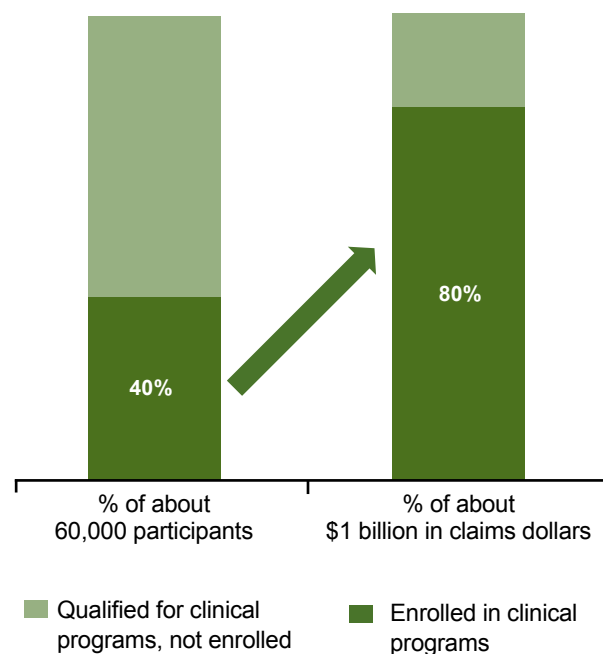
WE EDUCATE EMPLOYEES AND RETIREES ON AVAILABLE WELLNESS PROGRAMS. ERS provides multi-channel communications about wellness and the tools that are available to help participants to manage their health. We use direct mail, online communications, telephone outreach, face-to-face meetings and benefit fairs.

ERS WORKS WITH OTHER AGENCIES TO PROMOTE WELLNESS. Finally, ERS and the HealthSelect TPA are active with the State Worksite Wellness Advisory Council, and are helping identify opportunities to encourage and engage state employees, wellness coordinators and state agencies. We also help plan statewide wellness activities and events that come up during the year.

Engaging in a clinical management program helps a participant better manage his or her complex or chronic condition. For example, enrollees in clinical management programs are more likely to manage their illnesses by going to their doctors, monitoring their conditions with appropriate diagnostic tests and taking their medications. They are also less likely to be hospitalized or go to the emergency room, compared to people with poorly managed health conditions.

Figure 18: *HealthSelect successfully targets the highest risk participants for clinical programs with the greatest potential for savings.*

Enrolling the highest-risk 40% of those qualified for clinical programs targets 80% of the claims spend for that group



Tobacco premiums yielded \$15.3 million in contributions in FY14.

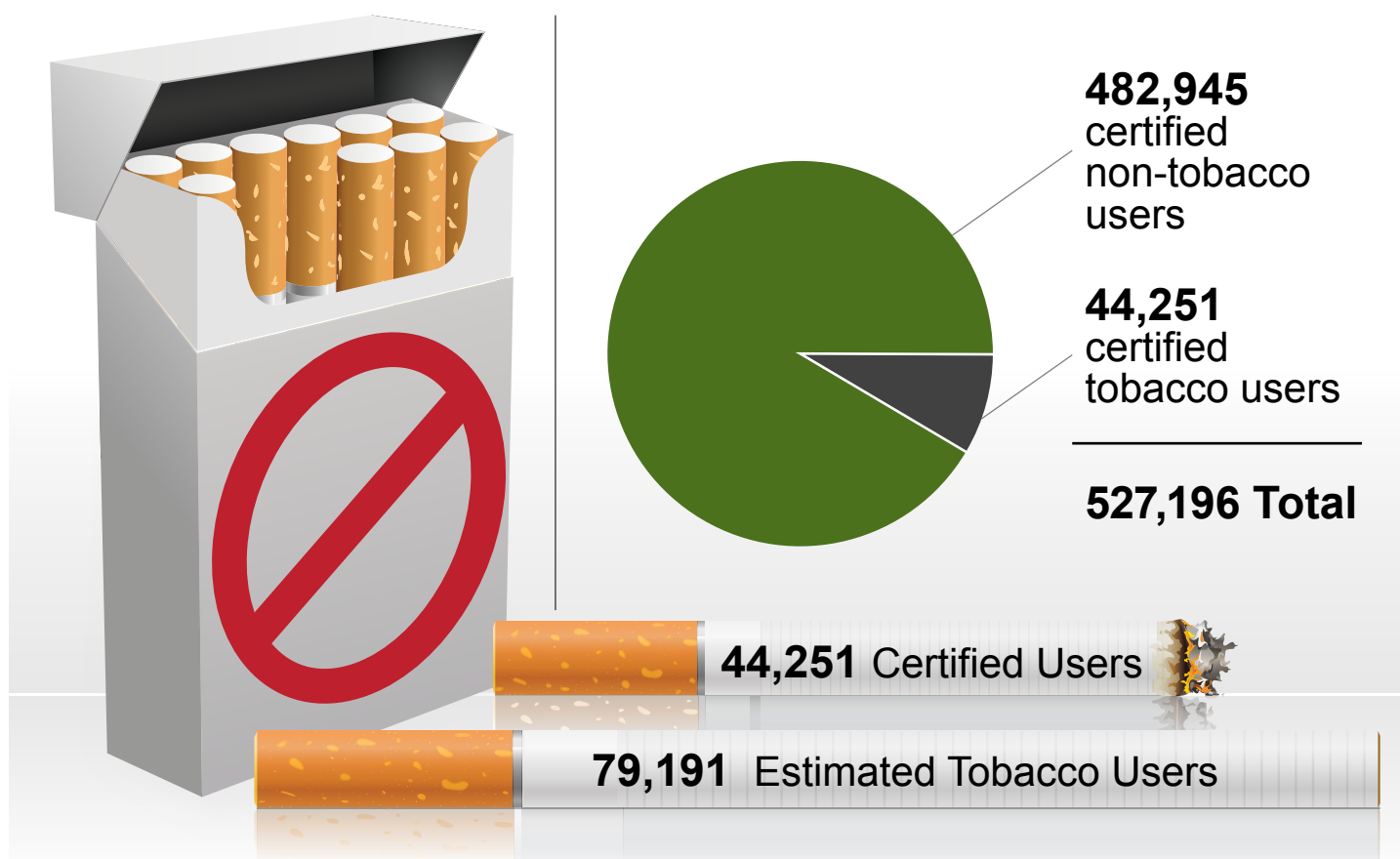
The 82nd Legislature enacted an “opt-in” or voluntary tobacco user premium contribution effective January 1, 2012. The program was designed to encourage and support people to stop using tobacco, by covering tobacco-cessation medications and offering voluntary tobacco-cessation support programs. Certified tobacco users pay an extra contribution of \$30 a month, up to \$90 per household.

The 83rd Legislature authorized ERS to mandate tobacco certification of all participants during Annual Enrollment for FY14. Those who failed to certify were assumed to be tobacco users and were charged the monthly tobacco premium contributions until they informed us they were no longer using tobacco. In FY14, ERS collected \$15.3 million in additional tobacco contributions from more than 44,000 participants who certified as tobacco users.

HealthSelect offers free tobacco cessation coaching programs, which have historically attracted extremely low participation. Only about 50 participants engaged in the voluntary HealthSelect tobacco cessation program in FY14.

HealthSelect also provides coverage for prescription drugs like Chantix and bupropion, both prescribed to help people quit using tobacco. In FY14, about 3,800 participants filled Chantix prescriptions, at an estimated cost to the plan of about \$550,000. However, it takes 12 weeks for Chantix to be effective, and at every 30-day interval, there was a 50% drop in usage. As with any medication, the plan only knows if the prescription was filled at a network pharmacy, not if it was taken.

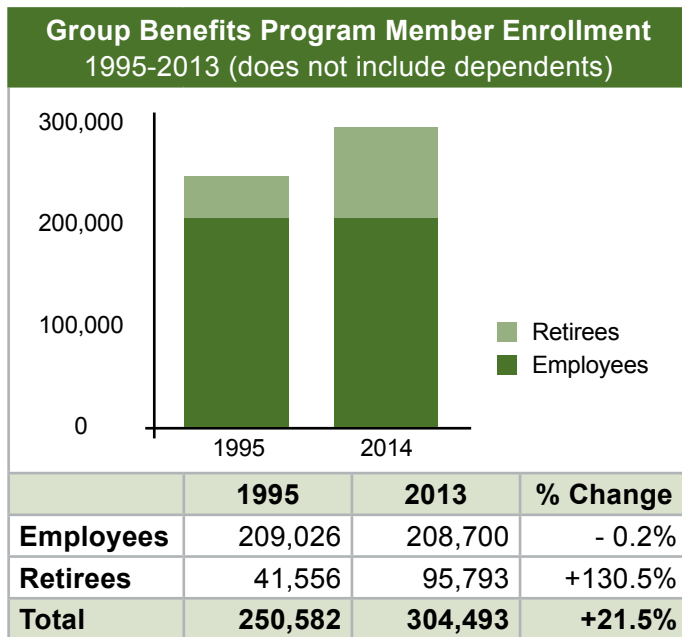
Figure 19: Requiring all GBP participants to certify their tobacco use in FY14 resulted in an 8% increase in the number of tobacco users paying the additional \$30 a month tobacco premium contribution.



RETIREE BENEFITS

Most state and local government employers offer health insurance benefits to their Medicare-primary retirees. Many private employers do not. Some employers offer a Medicare Advantage plan; others give retirees a set amount of money to buy a Medigap or Medicare Supplement policy on the open market.

Figure 20: *The entire increase in GBP member enrollment since 1995 is due to the retiree population more than doubling in 20 years.*



The importance of managing the cost of retiree health benefits cannot be overstated. Figure 20 shows that all of the growth in GBP enrollment since 1995 is due to a 131% increase in the retiree population. About two-thirds of the Medicare-primary population in the GBP has now moved to the fully-insured HealthSelect Medicare Advantage Plan, administered by Humana. One-third remain in HealthSelect or an HMO.

All retiree prescription drug costs are counted in this report, as the HealthSelect Medicare Rx plan is a self-funded drug plan. Not all Medicare-primary medical costs are counted here, as the MA plans are not part of the self-funded HealthSelect benefit.

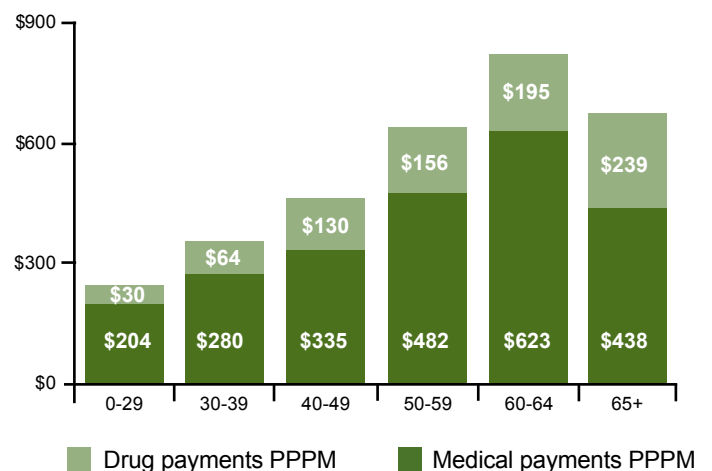
The Medicare Advantage option.

When GBP retirees and their dependents reach age 65 and become eligible for primary coverage under Medicare, they are automatically enrolled in HealthSelect MA. A GBP member enrolled in an MA plan does not have traditional Medicare or HealthSelect coverage. Retirees with an MA plan do not need a Medigap policy.

As seen in Figure 21, retirees have higher costs than active employees. Retirees without Medicare have the highest medical costs to the program, and retirees with Medicare have the highest prescription drug costs to the program.

Figure 21: *Retirees without Medicare have the highest average medical costs. Retirees with Medicare have the highest average pharmacy costs.*

(FY14 HealthSelect per participant per month (PPPM) plan cost, medical and pharmacy claims)



Medicare-primary participants can opt out of HealthSelect MA and choose from four other options: HealthSelect, two regional HMOs or a Houston-area Medicare Advantage HMO, KelseyCare Advantage. In FY14, about 64% of Medicare-primary retirees and their Medicare-primary spouses remained in the MA plans, while the rest chose HealthSelect or an HMO.

To get the most from their GBP benefits, Medicare-primary participants in all GBP health plans must have Medicare Part A (hospital) and Part B (other medical) coverage. Part A is free for Medicare-primary participants. The base premium for Part B coverage is \$105 a month, an amount that will not change in 2015. Part B premiums increase for retirees with incomes higher than \$85,000 a year.⁴

HealthSelect coordinates benefits with Medicare to pay most expenses not paid by Medicare. When retirees use doctors who accept Medicare, they have very low out-of-pocket costs under both HealthSelect MA and HealthSelect.

GBP monthly premiums for HealthSelect MA and KelseyCare Advantage are less expensive for the state and for the retiree because Medicare, as the primary payer, subsidizes a large portion of participant medical expenses. MA plan participants continue to receive prescription drug coverage through HealthSelect Medicare Rx. The benefits offered to GBP retirees under HealthSelect MA are comparable to HealthSelect.

Medicare Part D Retiree Drug Subsidy (RDS).

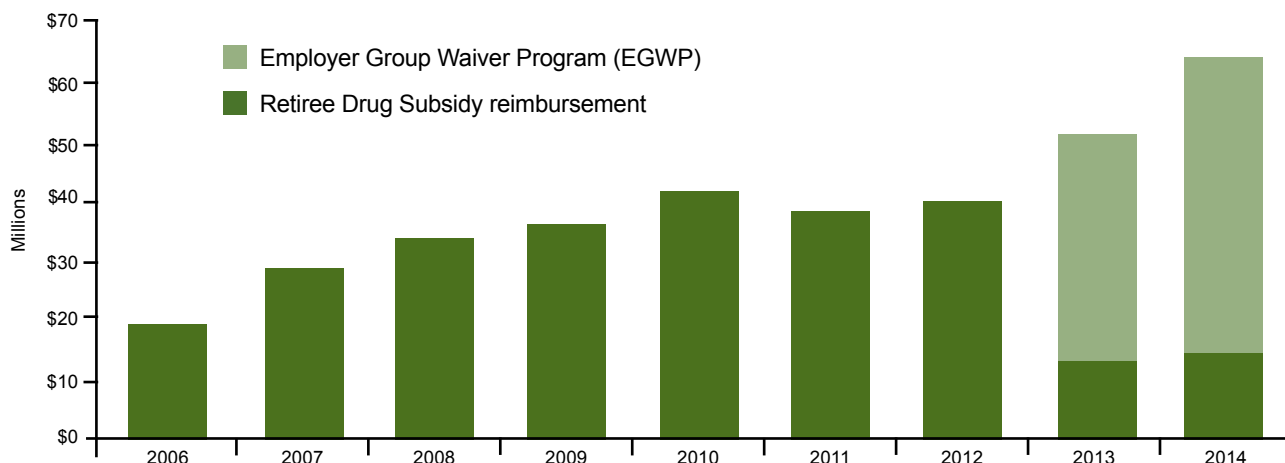
On January 1, 2006, Medicare retirees became eligible for federally subsidized prescription drug benefits through the federal Medicare Part D program.

The Medicare Modernization Act of 2003 created a number of subsidy options to encourage employer-sponsored insurance plans to continue drug coverage for Medicare-primary participants. The most popular of these approaches has been the Retiree Drug Subsidy. Over a nine-year period, HealthSelect collected \$264 million in RDS program subsidies.

During an ERS Solution Session in January 2012, a vendor presented an option for reopening HealthSelect's past RDS filings to identify and reclaim any missed reimbursements as far back as 2006. ERS contracted with a vendor for the reconciliation of past RDS filings, a process that netted an additional \$7 million in savings for the plan (included in the total above).

Figure 22: *New prescription drug program for Medicare-primary participants increases average annual subsidies to the plan over 60% since FY12.*

Federal Medicare Part D revenues for HealthSelect (FY06-FY14), in millions



Employer Group Waiver Program + Wraparound (EGWP).

On January 1, 2013, ERS moved the majority of Medicare-primary participants to an EGWP program called HealthSelect Medicare Rx. This is a basic Medicare Part D program that combines with a

wraparound feature to match the prescription drug benefits provided under HealthSelect.

Under HealthSelect Medicare Rx, the GBP is expected to receive \$63.4 million in combined Medicare Part D subsidies for 2014, a 25% increase over the \$50.9 million received in FY13.

⁴ Medicare Part A is free at age 65 as long as you have paid into Medicare for at least 40 quarters of your working career. Otherwise, you are charged a monthly premium. Medicare Part B has a monthly premium.

CONTRACTING

Managed care lowered FY14 charges by nearly \$4 billion

ERS contracts with vendors to process medical and prescription drug claims and build and maintain provider networks. The plan saves billions of dollars by negotiating contracts with a broad network of providers. The plan does not use standard contracts; rather, it develops and administers customized GBP contracts in the best interests of the participants, the programs, and the state.

In FY13, the administration of HealthSelect medical benefits successfully transitioned to a new TPA, UnitedHealthcare. The TPA contract remains on track to meet four-year administrative savings projections of \$25 million (compared to other administrative proposals). The prescription drug benefit programs continue to be administered by Caremark and SilverScript, without an increase in administrative fees.

About \$4 billion in charge reductions in FY14 came from discounted reimbursement rates with providers. The savings represent the discounts taken from the “retail” prices that doctors, hospitals, pharmacies and other providers would have charged the GBP had they not been covered by a managed care network.

Controlling costs through managing the network.

HealthSelect is a managed care plan that requires participants to stay “in network” to receive the highest level of benefits. Benefits are designed to save the plan money by offering financial incentives for participants to use contracted providers.

HealthSelect provides three levels of coverage:

- Network coverage means a participant must see a contracted primary care physician (PCP) or “gatekeeper” for specialist referrals or for extra services such as lab work, X-rays or MRIs.
- Non-network coverage refers to services provided by non-contracted providers who are outside the direction of a PCP. Participants can go out-of-network, but they pay more.

- Out-of-area coverage refers to coverage for those who reside outside of Texas or who are eligible for primary coverage under Medicare. Out-of-area coverage does not require the selection of a PCP or referrals. These services also cost the participants more.

ERS works closely with the TPA to monitor and manage HealthSelect network usage to identify and address gaps in network coverage. If a gap is identified, ERS works to fill those gaps through prioritizing the TPA's contracting efforts, and, in some cases, contracting directly with the provider.

The HealthSelect TPA has expanded network access to include 17% more providers.

Since September 1, 2012 the HealthSelect TPA has increased the provider network 17% to ensure that participants in all areas of the state have access and choice when using HealthSelect benefits. The TPA has made a special effort to bring providers into the network in traditionally tough-to-recruit specialties – like hospital-based physicians.

Patient-Centered Medical Homes – a blueprint for better care and lower cost

HealthSelect, like most employer-based plans, has historically paid claims under a “fee-for-service” (FFS) reimbursement strategy. FFS tends to reward doctors who prescribe more diagnostic tests and perform more procedures, not doctors who focus on low-cost preventive care and patient wellness.

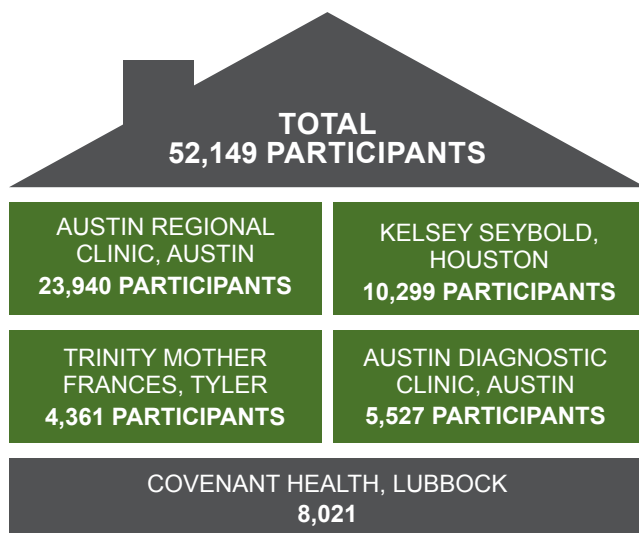
Moving away from FFS requires paying medical providers in new ways that reward them for reducing costs while continuing to meet quality standards. Recent state and federal legislative initiatives have encouraged insurers to explore alternative payment systems that reward providers for reducing costs and improving quality outcomes.

Between 2011 and 2014, ERS partnered with five large clinically integrated physician group practices across the state to create five Patient-Centered Medical Home (PCMH) projects, now treating more than 52,000 participants.

The PCMH model is a provider team made up of an integrated multi-specialty practice. This model generally:

- focuses on wellness and establishing an ongoing relationship with a personal primary care physician;
- uses advanced information technology;
- ensures that quality and safety standards are met through the use of evidence-based medicine and clinical decision-support tools;
- provides enhanced access, such as open scheduling, expanded hours and new options for communication between provider and participant (e.g., email); and
- awards shared-savings payments to the provider group when quality standards are met and cost targets are achieved.

Figure 23: *HealthSelect has five Patient-Centered Medical Home projects with more than 52,000 participants.*



Savings are shared with providers.

In addition to its regular FFS payments, HealthSelect pays each PCMH a negotiated monthly capitation payment for those participants who have selected the medical home as their primary care coordinator. The capitation payment is designed to incentivize enhanced care coordination not found in the standard FFS practice.

ERS also sets performance targets, designed to reduce the health benefit cost trend, while meeting quality standards of care. The PCMH projects have successfully reduced the health benefit cost trend below their performance targets. In the first three years, the PCMH project produced a net savings to the state of \$31.4 million and the practices received \$7.3 million in shared-savings payments, in addition to their reimbursements for medical care. FY14 shared-savings payments will be announced in January 2015.

With the help of the HealthSelect TPA, the PCMH practices are changing their prescribing patterns and improving quality of care. The participants being served by PCMH projects have reduced rates of emergency room visits and inpatient hospital stays, increased rates of cholesterol and diabetes testing, and increased use of generic prescriptions.

ERS wins national recognition for PCMH program.

In April, 2014, ERS received national recognition for its PCMH project from the State and Local Government Benefits Association (SALGBA) — winning the SALGBA Challenge grand prize for innovative best practices.

The SALGBA awards ceremony noted that while many states – including Texas – are incorporating medical home concepts into their medicaid managed care programs, and some public employee health insurance programs have tagged on to multi-payer alternative payment systems, ERS is a rare example of a state employee benefits administrator implementing a PCMH project on its own.

ERS is implementing best practices.

Extensive study and benchmarking research has shown that ERS has already implemented many best practices found in the marketplace. For example, ERS started offering “Solution Sessions” in 2012, a formalized, transparent process for vendors to present cost saving ideas for the GBP.

Since then, more than three dozen vendors have presented at open meetings, held at ERS and live-streamed over the internet. As a result, ERS has implemented a number of Solution Session ideas, and has institutionalized an open government approach to gathering new ideas for the program.

CONCLUSION

Proactive cost management is an imperative in the face of growing utilization of drugs and medical services, new technology and more expensive treatments, an aging plan membership, increasing rates of chronic diseases and limited resources.

ERS lowered health plan costs by \$5.8 billion in FY14 through tough cost-management practices, aggressive negotiation of contracts and low administrative overhead. HealthSelect administrative costs represent less than three cents of every health plan dollar.

Successful management and legislative support of the program allowed the GBP to avoid benefit changes for the FY14-15 biennium. But the future will continue to present some difficult challenges for ERS, state lawmakers, and especially for the employees, retirees and their families who count on these health insurance benefits.

ERS is proactively managing retiree costs.

While the number of active employees in the GBP is holding steady, Figure 24 shows how the retiree population has more than doubled since 1995. In fact, a 25% growth in GBP membership over two decades is due entirely to the growing retiree population.

Managing costs for an aging health plan is paramount. In the past several years, ERS has successfully implemented new health and pharmacy plans for the Medicare-primary retiree population. These initiatives continue to produce savings for the plan, and they reduce contributions for members with dependents enrolled in the Medicare Advantage plans.

The GBP has a significant impact on the Texas economy.

One in 52 Texans – more than half a million state and higher education employees, retirees and their families — are currently enrolled in ERS health coverages, in every area of the state. It's important to recognize the economic impact that the plan has on local health providers too. The GBP currently spends about \$7 million a day on health care claims. HealthSelect, with 84% of total GBP membership, paid \$2.3 billion in health payments last year to doctors, hospitals and pharmacies across Texas. That's \$2.3 billion in income to local health care providers.

Figure 24: Since 1995, the GBP retiree population has more than doubled. (Retirees enrolled in the GBP, 1995 – 2014)

The increasing number of retirees adds cost, creating long-term challenges for the plan

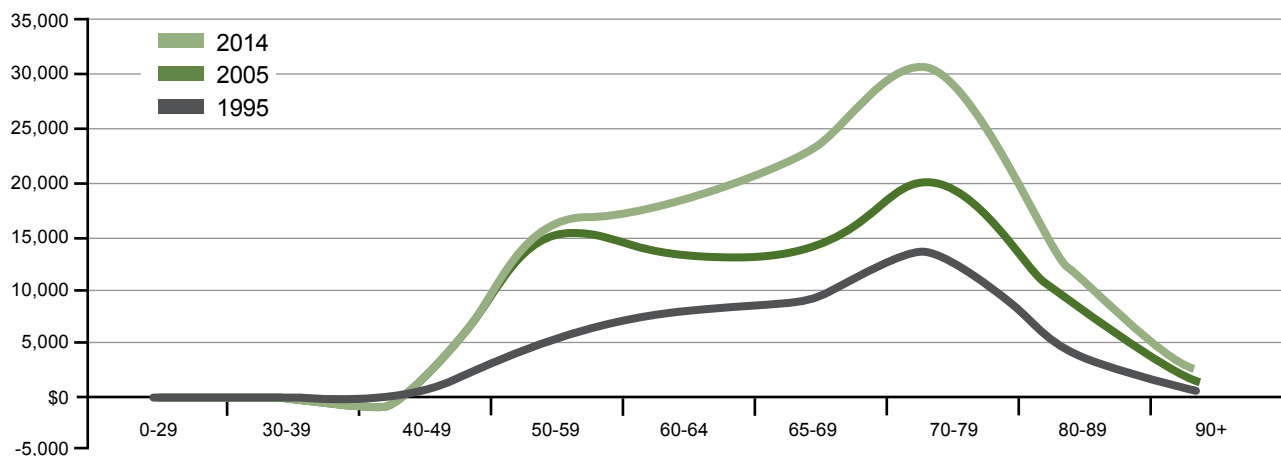
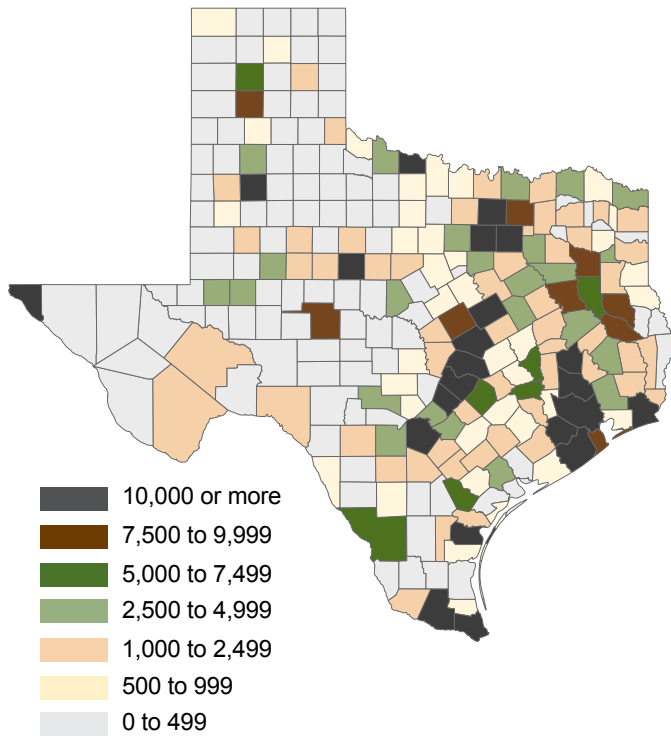


Figure 25: The GBP has a significant economic impact on the Texas economy.

Number of ERS participants in GBP insurance by county, FY14



Without cost management, the state's insurance contribution would more than triple.

In FY14, the member-only contribution rate for FY14 was \$500.92 per month. Figure 26 on page 33 demonstrates the financial impact that cost management programs had on the monthly contribution rate for member-only coverage during FY14. Without cost-management programs, the monthly contribution rate for member-only coverage would have been \$1,750.

Looking Ahead

The 83rd Texas Legislature took a key step toward reducing the state's health care costs for the retiree population by passing a tiered contribution strategy that will require non-grandfathered retirees to have at least 20 years of service to qualify for a 100% member contribution from the state. As of September 1, 2014, non-grandfathered employees who retire with 10-15 years will pay 50% of the contributions for their health coverage, and those with 15-20 years will pay 25% of their contributions for their health coverage.

During the interim, SB1, Rider 14 directed ERS to study member preferences for less costly health plans and present them to the Legislature for consideration. The study followed up on a finding from the FY12 ERS Interim Benefits Study that lower-income employees may be turning down dependent care coverage because they can't afford it. We learned that this is true for a small subset of employees, especially low-income employees at certain state agencies. As many as one out of 10 GBP-eligible children is either uninsured or enrolled in Medicaid or CHIP.

ERS could offer more plan choices if it had more funding flexibility.

About half of private-sector employers are designing plans to encourage consumers to control their individual health care costs, primarily through consumer-directed health plans (or high deductible health plans with health savings accounts).

A small subset of GBP members with dependents said they might be interested in a lower premium (high-deductible) health plan if it were offered. But as ERS has reported in the past, without a change in the contribution strategy, the GBP is unable to provide meaningful choices among benefit plans. The findings of this study are explored in Appendix C.

Prescription drug costs will be an ongoing challenge.

Taking the macro-level view on specialty drugs, it's important to continue tracking specialty claims, looking at who is at risk in the population that uses those drugs and the unintended consequences on patient health of not using the drugs.

For example, the Centers for Disease Control and Prevention (CDC) warns that Hepatitis C (Hep C) is a hidden epidemic for the Baby Boomer population, predicting that people born between 1945 and 1965 are five times more likely than other adults to be infected. Hep C is a liver disease that results from a viral infection, causing serious health problems like liver damage and cirrhosis. It is a leading cause of liver cancer and the leading reason for liver transplants. The CDC believes that one-time testing for this group would find an estimated 800,000 undiagnosed cases.⁵

⁵ Centers for Disease Control and Prevention, "Hepatitis C Testing for Anyone Born During 1945-1965: New CDC Recommendations, October 1, 2012.

A new Hep C drug called Sovaldi was released in FY14, rising to number 7 on the HealthSelect Top 10 most costly drug list in just nine months. This drug has a potential 95% cure rate for appropriate candidates, which may improve their health enough to outweigh the plan cost associated with covering the drug. For example, an \$85,000 treatment of Sovaldi could prevent a costly liver transplant down the line. But this may not be the outcome for all Hep C patients. And by the end of 2014, Solvadi and other Hep C treatments were largely replaced by Harvoni, which costs \$95,000 for a 12-week course of treatment.

The plan's options for addressing prescription drug price inflation are limited. The HealthSelect plan is large enough in Texas to move market share to some extent, by adding more competitively priced drugs to the formulary. HealthSelect could remove particularly pricey medications from the formulary when a less expensive equivalent drug of similar efficacy is available. Since the start of FY15, step therapy is required for certain therapeutic classes of drugs, such as anti-inflammatories and medications that reduce high blood pressure.

ERS will continue to lead the way with innovative payment models.

ERS took early steps to implement an innovative payment approach with its PCMH project – prior to the passage of federal health care reform legislation. Although legislative leadership was supportive, no additional state funding was appropriated for these programs. The PCMH projects are replicable models, built with existing resources, designed to improve health and create a sustainable impact on plan costs.

ERS took a chance on the PCMH project, paving the way for others with the belief that it was the right thing to do. Now, with five successful medical homes in place, ERS has a unique opportunity to drive the market and create a positive change in the way thousands of Texans experience care. In areas with a PCMH practice, nearly 30% of HealthSelect patients see a PCMH primary-care physician.

The HealthSelect PCMH project was recognized by other state and local government health plans as a blueprint for those wanting to implement meaningful rewards for high-performing providers through a self-funded insurance plan. Of course, truly lasting change depends upon individuals taking an active role in managing their own health. ERS believes that providing as many members as possible with a PCMH to call “home” could be the tipping point for those who benefit from a better coordinated health care strategy.

Affordable Care Act costs are primarily due to fees and reducing member cost sharing.

The cost of ACA-related fees will peak in FY15, then taper off as one of the costliest fees for HealthSelect – the transitional reinsurance fee – is phased out. In the coming biennium, total plan costs are projected to level off at about \$124 million per year. A coming ACA development to watch is a new maximum cap on out-of-pocket health care costs. This means that starting January 1, 2016, once an individual spends \$6,350 or a family spends \$12,700 on medical and pharmacy, the plan will pick up the rest of the tab. While most participants never come close to spending this much money on their health care in a year, for some of the very sickest people who rely on the health plan, it will provide some financial relief.

ERS continues to work ahead of the curve to maintain competitive, comprehensive benefits at a reasonable cost. However, the program needs coordinated action to make further inroads on reducing plan costs. Attracting and retaining a qualified state workforce is a prime objective in a total compensation philosophy. When asked, employees consistently name health insurance as their most valued benefit. We look forward to working with the Legislature to find cost effective ways to continue offering a benefit that not only provides a competitive advantage to state employers, but also shows that the State of Texas values a healthy productive workforce.

Figure 26: *Texas Employees Group Benefits Program, HealthSelect FY14, cost containment impact on the member-only rate.*

	Annual Amount		Required Monthly Revenue for Member-only Coverage		
1 Considered Charges plus Estimated Cost Avoided		\$8,078,961,102		\$1,749.82	
2 Estimated Cost Avoided					
a. Medical	(\$60,632,473)	(90,938,134)	(\$13.13)	(19.69)	
b. Pharmacy	(30,305,661)		(6.56)		
4 Ineligible Charges		(853,440,041)		(184.85)	
6 Reductions to Eligible Charges					
a. PDP Charge Reductions	(\$756,236,499)		(\$163.79)		
b. Other Facility & Professional Discounts & Reductions	(\$3,219,277,320)		(697.26)		
c. Medical Copayments and Deductibles	(110,398,685)		(23.91)		
d. Medical Coinsurance	(193,163,702)		(41.84)		
e. PDP Cost Sharing	(161,019,803)		(34.88)		
f. Coordination of Benefits – Medical - Non Medicare	(22,814,477)		(4.94)		
g. Coordination of Benefits – Medical - Medicare	(157,764,154)		(34.17)		
h. Coordination of Benefits - PDP	(1,169,192)	(4,621,843,832)	(0.25)	(1,001.05)	
8 Refunds, Rebates and Guarantees					
a. PDP Rebates	(\$130,156,969)		(\$28.19)		
b. Federal Revenue - Medicare Part D	(63,361,490)		(13.72)		
c. Subrogation	(3,788,243)		(0.82)		
d. Pharmacy Audit Refunds	(859,359)		(0.19)		
e. PBM Audit Refunds	(1,805,895)	(199,971,956)	(0.39)	(43.31)	
9 Net Benefit Payments		\$2,312,767,138	\$500.92	\$500.92	Monthly Member Rate

APPENDIX A: Impact of the Affordable Care Act on the GBP

The Texas Legislature amended state law in 2011 and 2013 to bring the GBP into compliance with the requirements of the Affordable Care Act (ACA). ERS has implemented all required ACA-related changes to date.

The GBP saw a net gain of about \$36 million to the program in FY11 and FY12 as ACA subsidies exceeded the cost of ACA mandates. Since FY13, ACA-related costs have increased annually. More than half of the increased costs in FY14 are due to the plan covering 100% of the cost of preventive care services.

About 25% of the increased costs to the GBP projected through FY15 are due to new fees required by the ACA. Only one of the new fees is permanent, and it does not apply to HealthSelect.

According to ACA standards, ERS manages an extremely cost-efficient plan. The ACA requires large employer plans to spend at least 85 cents of every dollar they collect on health care claims. The HealthSelect program spends more than 97 cents of every dollar on health care claims.

PROJECTED ADDITIONAL PLAN COST/ (SAVINGS) FY11 - FY17 RELATED TO THE AFFORDABLE CARE ACT¹ (REVISED JULY, 2014)

	Projected Plan Cost/(Savings) (\$millions) ²				
	FY13	FY14	FY15	FY16	FY17
1. ERRP ³	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
2. Eliminate Lifetime Maximum for Out-of-Network Services	\$0.3	\$0.3	\$0.3	\$0.4	\$0.4
3. Expand Coverage to Dependents to Age 26	\$12.4	\$13.8	\$15.3	\$16.7	\$18.2
4. Cover Preventive Care at 100%	\$26.4	\$28.1	\$30.5	\$32.3	\$34.1
5. Cover Contraceptives at 100%	\$8.8	\$9.7	\$10.7	\$11.5	\$12.4
6. Reduce Waiting Period	\$0.0	\$0.0	\$19.4	\$20.8	\$22.3
7. Implement Maximum Member Cost Sharing	\$0.0	\$0.0	\$0.9	\$2.2	\$2.3
8. Change Definition of Full Time Employee from 40 to 30 Hours per Week ⁴	\$0.0	\$4.0	\$4.3	\$4.6	\$4.9
9. Patient Centered Outcomes Research Trust (PCORT) Fee ⁵	\$0.5	\$1.1	\$1.1	\$1.2	\$1.3
10. Transitional Reinsurance Program Fee ⁶	\$0.0	\$18.6	\$22.7	\$14.8	\$4.1
11. Health Insurance Provider Fee ⁷	\$0.0	\$9.2	\$17.6	\$19.5	\$22.5
Total	\$48.4	\$84.8	\$122.8	\$124.0	\$122.5

¹Projected additional Plan Cost/(Savings) to the GBP for all employers and members. Negative amounts denote savings to the GBP.

²Projected Plan Cost/(Savings) represents costs/savings incurred in fiscal year, except as noted in Footnote 3 below.

³Funds received from the federal government: \$30.2M received in FY11 based on claims incurred in FY10 and FY11; \$40.7M received in FY12 based on claims incurred in FY11.

⁴Amounts shown are projected additional employer contributions.

⁵The PCORT fee helps fund the Patient-Centered Outcomes Research Institute's research on the comparative effectiveness of medical treatments.

⁶The Transitional Reinsurance Fee is designed to spread financial risk across insurers to assist plans that attract individuals at risk for high claims costs. This fee does not affect the Medicare Advantage plans. It will be phased out after December 31, 2016.

⁷Projected Health Insurance Plan Fees will fund premium tax subsidies for low-income people and their families who purchase insurance through the exchange. It will be permanent starting in Calendar Year 2014 and is paid by GBP insurers. HealthSelect and Community First HMO are exempt from this fee.

APPENDIX B: Financial Status of the Group Benefits Program, FY14

Texas Employees Group Benefits Program, Summary of Health Plan Experience All GBP Health Plans Based on Experience through September 2014.			
\$Millions			
	FY13	Projected FY14	Projected FY15
Revenue from State/Members			
Employer contributions for state agencies	\$1,407.5	\$1,520.9	\$1,662.5
Employer contributions for higher education	589.3	643.5	703.8
Employer contributions – non-state agencies	57.3	62.4	68.2
Employer Contributions – total	\$2,054.1	\$2,226.8	\$2,434.5
Member contributions	415.0	435.8	467.0
Other revenue	115.9	170.1	157.8
TOTAL REVENUE	2,585.0	\$2,832.7	\$3,059.3
HEALTH CARE EXPENDITURES	\$2,544.4	\$2,778.8	\$3,091.7
Net Gain/(Loss)	40.6	53.9	(32.4)
Fund Balance	\$325.4	\$379.3	\$346.9
Other Expenses Incurred Outside of the GBP Fund			
Member cost-sharing (copays, coinsurance and deductibles)	\$496.5	\$490.2	\$498.1

Projected Average Annual Cost Trends for HealthSelect (FY15-17)

	Increased Use of Service	Industry Price Increases	Maintenance of Member Cost Share	Total
Hospital	2.3%	5.6%	0.6%	8.5%
Other Medical Expense	0.9%	1.9%	0.2%	3.0%
Pharmacy	4.5%	6.3%	3.5%	14.3%
Total	2.5%	4.9%	1.2%	8.6%

The rates presented above represent the gross (underlying) health benefit cost trends prior to recognition of benefit, legislative and/or administrative changes that could be expected to impact health benefit cost.

APPENDIX C: Interim Study on Alternative Health Plan Options for State Employees

SB1, Rider 14 (83rd Session) directed ERS to examine the impact of offering alternative health plan options for state employees. The study was prompted by employer concerns that “many state employees in low-wage, high-stress, high-turnover jobs cannot afford dependent coverage.”

ERS hired an independent research firm to conduct a census of 136,142 GBP-enrolled state employees, with a special outreach to those earning less than \$40,000. The sample included 3,000 higher education employees with state service.

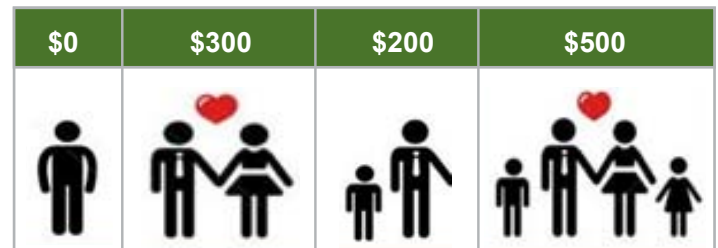
Survey findings.

- A small percentage of respondents said their children (3.7%) or their spouses (5.5%) are uninsured – potentially 6,400 eligible children and 4,800 eligible spouses of state and higher education employees.⁶
- One in 10 GBP-eligible children (~18,000) is uninsured, or enrolled in Medicaid or CHIP.
- About 70% of respondents with uninsured dependents earn less than \$40,000 a year.
- The primary reason cited for turning down GBP dependent coverage was the premium cost.
- The incidence of uninsured children and spouses is higher at some agencies, such as the Texas Department of Criminal Justice and the Health and Human Services agencies. These employers experience high turnover in critical positions, so this is not just a health care concern, but also a recruitment and retention issue.
- About 25% of all respondents with eligible dependents said they might consider a high-deductible plan (HDHP) with a reduced or zero (\$0) premium.
- Thirty-nine percent of the 3.7% of employees with uninsured children said they might consider a HDHP.

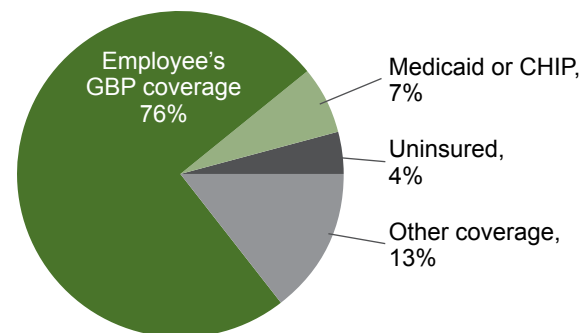
ERS could offer a lower-level plan (or two) with minimal actuarial impact on HealthSelect enrollment levels, the risk pool or the soundness of the plan. However: the current contribution strategy does not allow ERS to price benefits in a way that encourages members to take a lower-level plan; and an HDHP without an attached health savings account provides little incentive for employees to take on the added risk of a high deductible.

In order to offer the discounted or zero-premium plans modeled in the survey, the Legislature would need to change the contribution strategy (through statute and a rider in the appropriations bill), and depending on the extent of changes to the plan, it could also require changes to Texas Insurance Code, §1551.

Employee’s Monthly Cost for Health Insurance Coverage



About one in 10 GBP-eligible children is uninsured, or enrolled in Medicaid or CHIP



JACK, a 41-year-old correctional officer at Texas Department of Criminal Justice earns \$35,700.

The \$515 GBP premium for Jack, his wife and three kids is 17% of his gross income. His children qualify for Medicaid.

⁶ Assumptions about the state employee population were extrapolated to the higher education employee population. Because just 3,000 higher-education employees with state service were surveyed, these extrapolated numbers cannot be verified as statistically valid. However, ERS believes they are a reasonable estimate, given the available data.

APPENDIX D: Glossary of Terms

Affordable Care Act (ACA): A federal statute signed into law by President Barack Obama on March 23, 2010, enacting significant regulatory reforms of the U.S. healthcare system.

Adverse selection: In health insurance, when multiple plans are offered, adverse selection occurs when people avoid buying higher levels of insurance benefits unless they are sure they will benefit from it.

Capitation: A fixed provider payment amount per person regardless of type or amount of health care services used.

Compound drugs: Compound drugs are specially formulated combinations of two or more medications made in compounding pharmacies.

Contingency fund: The amount of health plan assets that remain in the ERS Insurance Trust after all liabilities have been accounted for. The contingency fund's intended use is to cover unanticipated expenses arising from adverse fluctuations in claim costs or an unforeseen event such as a flu pandemic.

Contribution rate: The amount that the employer and member must pay for health insurance coverage (expressed in dollars). The GBP rate, set by the ERS Board of Trustees, divides the actual health plan costs between employers and members based on the contribution strategy established by the Legislature.

Contribution strategy: Set by the Legislature; outlines what portion of health plan premium contribution costs will be paid by the employer and what will be paid by the members (expressed as a percentage). Currently, the employer pays 100% of the cost for member-only coverage and 50% of the cost for dependent coverage.

Coordination of benefits (COB): Divides health care expenses among responsible payers, ensuring that HealthSelect doesn't pay claims that may be covered elsewhere.

Employer Group Waiver Plan + Wrap (EGWP): A basic Medicare Part D program combined with a wraparound provision that brings the plan design up to par with current employer coverage. The EGWP allows plan sponsors to offset prescription drug costs incurred by plan members through federal subsidies.

Fee-for-service (FFS) reimbursement: A payment model in which providers are paid for each service they perform.

Fully insured model: A model in which the employer contracts with an insurance company to assume financial responsibility for claims and administrative costs.

Generic dispensing rate (GDR): The percentage of all filled prescriptions composed of generic medications.

Grandfathering: When an old rule applies to an existing group of participants (or situation) and a new rule applies to a future group of participants (or situation).

Health benefit cost trend: A complex measure of the annual rate of change in payments to health care providers, including price inflation, the mix of services provided and changes in health care utilization.

Health Insurance Plan Fee: Permanent ACA-required fee (effective January 1, 2014) that funds premium tax subsidies for low-income people and their families who purchase insurance through the exchange. HealthSelect and Community First HMO are exempt from this fee.

HMO plan: A pre-paid health program where healthcare services are provided through a closed provider network.

Health savings account (HSA): A tax-favored account that individuals use to pay qualified medical expenses; a tax-free way to save for expected health care expenses. HSAs are portable and funds are carried over without limit from year to year.

Managed care: A cost-management practice that negotiates discounted reimbursement rates with providers who agree to participate in the network. Participants pay less for using network providers; they pay more for using out-of-network providers.

Medicare Advantage plan: A type of insurance plan that is provided by private insurance companies. It replaces traditional Medicare and Medicare supplement coverage with a single plan and administration.

Medicare Part A: This part of Medicare pertains to hospital insurance.

Medicare Part B: This part of Medicare pertains to other medical insurance.

Medicare Part D: This part of Medicare is a separate insurance policy just for prescription drugs.

Member cost share leveraging: When the benefit design consists of fixed copays, the plan will bear a larger share of cost increases over time, while member copays stay the same.

Patient-Centered Outcomes Research Institute fee:

This ACA-required fee helps fund research on the comparative effectiveness of medical treatments.

Point-of-service (POS) plan: A type of managed care insurance plan in which the member chooses a network primary care physician (a “gatekeeper”) who provides and directs all of his medical care, including specialist referrals. Members pay more if they choose out-of-network providers.

Pre-payment claims editing: Screening submitted charges for duplicate claims or late fees, non-covered services or facilities or services that are not medically necessary.

Health Insurance Plan Fee: Permanent ACA-required fee (effective January 1, 2014) that funds premium tax subsidies for low-income people and their families who purchase insurance through the exchange. HealthSelect and Community First HMO are exempt from this fee.

Retiree drug subsidy (RDS): A federal program under Medicare Part D that subsidizes a portion of eligible-retiree drug costs. To receive subsidies, the plan sponsor must continue to offer employer-provided drug coverage to retirees who would have otherwise enrolled in Medicare Part D.

Risk pool: The total number of participants eligible for coverage under the plan regardless of whether or not they are enrolled in the plan.

Self-funded model: A model in which the employer and the participants – not an insurance company – assume direct responsibility for funding health care claims. Employers and employees pay for the plan and bear the risk that the revenue collected will be enough to pay all care claims during the year.

Specialty drugs: Expensive medications prescribed for complex chronic and/or life threatening conditions. They often require special storage, handling and administration, and they involve a significant degree of patient education, monitoring and management.

Step therapy: A cost-containment policy that requires members to try less expensive drugs before the plan covers a more expensive brand-name drug. Also called “Step protocol.”

Subrogation: Allows the plan to recover certain health-related expenses paid on behalf of a participant who has rights of recovery against a third party for negligence or any willful act resulting in injury or illness to the participant.

Transitional Reinsurance Fee: An ACA-required fee that is designed to spread financial risk across insurers to assist plans that attract individuals at risk for high claims costs. This fee does not affect the Medicare Advantage plans. It will be phased out after December 31, 2016.

Utilization: A measure of how often members go to the doctor, get services or fill prescriptions.

Utilization management: A process that highlights cost drivers, identifies people eligible for clinical management programs and encourages coordination of care by ensuring that primary care doctors are involved in treatment decisions and prescribed services are aligned with best-practice standards.

Value-based incentive design (VBID): This type of plan design aligns incentives with the clinical value (as opposed to acquisition cost) of the drug or service. Incentives can include monetary rewards, reduced premium shares, or lower deductibles and copays.

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